PATIENT-THERAPIST NEED COMPATIBILITY AND EXPECTATION OF PSYCHOTHERAPEUTIC OUTCOME

By

NOEL ARTHUR PLUMMER

A DISSERTATION PRESENTED TO THE GRADUATE COUNCIL OF
THE UNIVERSITY OF FLORIDA
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

APRIL, 1966

University of Florida
1853

UNIVERSITY OF FLORIDA
3 1262 08552 2208

ACKNOWLEDGMENTS

I wish to express appreciation and acknowledgment of the help and guidance of those who aided in the completion of this dissertation. Without their help, a study of this nature could not have been attempted.

Deepest appreciation is due my chairman, Dr. Audrey S. Schumacher. Her contributions covered a wide range of involvement from encouragement through sympathy, instruction, construction, guidance and challenge.

I wish to thank Dr. Benjamin Barger for his dual contribution as a committee member and as Director of the Mental Health Clinic where some of the subjects were secured. I also wish to thank the other members of the committee; Dr. Richard Anderson, Dr. James Dixon and Dr. Milan Kolarik for their concern and thoughtful suggestions regarding hypotheses formulation and statistics, and Dr. George Bartlett for his interest.

I wish to thank Dr. Thomas Martin, Director of the University Counseling Center and the office staffs at both the Counseling Center and Mental Health Clinic for their help in obtaining subjects, and Dr. David Lane for his interest and permission to use the reproduced portions of the counseling films for the study.

Especially I wish to express appreciation to the students who gave so willingly of their precious time. Without them, there would

have been no study.

And finally, to my wife and children, I must express my sincere gratitude, to Nancy, for her work in the numerous early typings, and acceptance of considerable neglect and stress in some very trying times, and to all concerned for helping to make the effort of research more meaningful.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	ii
LIST OF TABLES	vi
LIST OF FIGURES.	viii
CHAPTER	
I INTRODUCTION	1
Development of Hypotheses.	7
Hypotheses to be Tested.	10
II METHOD.	12
Subjects	12
Measures of Patient's Needs.	13
Measures of Therapist's Needs as Perceived by Patients	19
Measures of Patient's Expectations for Outcome	24
Testing of Hypotheses.	26
III RESULTS	31
Effect of Presentation Order of Therapist Films	48
Perceived Characteristics of Therapists.	54
IV DISCUSSION.	58
V SUMMARY	67

Table of Contents, Continued

	Page
APPENDICES	72
REFERENCES	99
BIOGRAPHICAL SKETCH.	101

LIST OF TABLES

Table		Page
1	PIT to FIRO-B Conversion Table	19
2	Reliability of Patients' Perceptions of Therapists (on PIT) Needs Using Alternate Rating Forms	22
3	Reliability of Patients' Perceptions of Therapists on PIT Needs.	23
4	Differences between Mean Scores on Semantic Differential Factors for the Most, Second and Least Preferred Therapists.	25
5	Differences between Mean Scores for Discrepancies between Patients' Value Rankings of Own Needs and of Therapist Needs.	32
6	Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Valued Needs and Scores of Therapists' Needs . .	36
7	Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Valued Needs and Scores of Therapists' Needs . .	37
8	Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Devalued Needs and Scores of Therapists' Needs .	38
9	Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Devalued Needs and Scores of Therapists' Needs .	39
10	Differences between Mean Scores for Discrepancies between Patients' FIRO-B Wanted Score Converted to PIT Needs and Scores of Therapists' Needs . .	40
11	Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Affectional Needs with Individual Patient Scores Combined. .	41
12	Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Inclusion Needs with Individual Patient Scores Combined. .	41

List of Tables, Continued

Table		Page
13	Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Control Needs with Individual Patient Scores Combined	42
14	Mean Discrepancy Score Distribution for the Three Therapists for FIRO-B Control Needs with Individual Patient Scores Combined. . .	44
15	Mean Discrepancy Score Distribution for the Three Therapists for FIRO-B Control Needs with Wanted Score Greater than the Expressed Score and Individual Patient Scores Combined . . .	45
16	Mean Discrepancy Score Distribution for the Three Therapists for FIRO-B Control Needs with Expressed Score Greater than the Wanted Score and Individual Patient Scores Combined	46
17	Analysis of Variance of Adjusted Scores for Discrepancies between the Patients' FIRO-B Control Needs Converted to PIT Needs and Scores of Therapists' Needs when Patients' Wanted Score is Greater than the Expressed Score and all Control Need Scores Combined	48
18	Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Control Needs Converted to PIT Needs and Scores for Therapists' Needs when Patients' Wanted Score is Greater than the Expressed Score with Individual Needs Combined	50
19	A Comparison of Presentation Order with Preference Order of Therapists	51
20	A Comparison of the Preference Order and the Frequencies of Therapist Choice.	52
21	Chi-Square Analyses of Individual Therapist Preference for Each Presentation	53
22	T-tests between Therapists' Mean Scores on 21 PIT Needs as Characterized by Patients	56

LIST OF FIGURES

Figure Page

1 Mean Scores of Perceived (PIT) Needs of Therapists 98

CHAPTER I

INTRODUCTION

Psychotherapy as a scientific discipline is barely 75 years old. Broadly speaking, however, it is as old as mankind. The healing effects of a human relationship have always been recognized, at least implicitly (Szasz, Knoff and Hollender, 1958). The human relationship between patient and therapist is central to many contemporary conceptions of psychotherapy. Psychotherapy as a process and the patient-therapist relationship have often been the objects of study. Originally, observations by the therapist and written case accounts were the only methods of study. These were, of course, influenced considerably by the personal feelings and theoretical positions of the therapist. Later, observation rooms and recording devices permitted others to see and hear the events which happened in the therapy hour. These observations were also subject to considerable distortion and lacked the precision which was beginning to characterize a large part of the psychological literature in other areas.

Many professional people began to urge that psychotherapy should also be subjected to experimental investigation. Others rejected this idea stating that psychotherapy was so complex and dependent upon the art of the therapist that scientific investigations of it were considered almost impossible. Strupp (1962) however, has stated, "To the extent that psychotherapy attempts a systematic and self-conscious manipulation of variables in a human relationship and notes its effects,

it has the makings of a scientific discipline" (p. 577). Research in psychotherapy has been extremely difficult due in part to the number of pertinent variables and their interactive effects.

One of the most promising lines of research upon the process of psychotherapy which retains some of the necessary complexity focuses upon the relationship between the patient and therapist. These studies have emphasized the patient and therapist personality variables which interact to increase the probability of favorable outcome in therapy. Hiler (1958) studied the characteristics of the therapist which might influence the patient to remain in or to discontinue therapy. Using the total number of Rorschach responses as an indirect measure of the patient's motivation for therapy, he showed that therapists who were rated by colleagues as most warm and friendly tended to keep in therapy a large percentage of unproductive patients. Furthermore, therapists who were rated as more competent tended to lose fewer productive patients. As Hiler points out, staying in therapy, while not synonymous with favorable outcome, is an indispensable prerequisite. In a study of client dependency and therapist expectancy as relationship maintaining variables in psychotherapy, Heller and Goldstein (1961) have shown that favorable therapy expectation may help in maintaining the therapeutic relationship. Drop-out rates were significantly influenced by pre-therapy attraction.

The effect of the initial impressions or expectations held by the participants in psychotherapy is one of the important aspects of the patient-therapist interaction and the psychotherapeutic process. The patient's initial impressions of the therapist, and the patient's

expectations for favorable or unfavorable outcome are seen to be important factors which may well influence the nature of the interaction and the eventual outcome of therapy. Parloff (1956) investigated the influences of the therapist's personality and his perception of the patient upon the quality of the therapeutic relationship. He studied the relationships that each of two expert therapists established with the same patients in group therapy. He was able to conclude that the therapist who perceives the patient as more closely approximating his "ideal patient" concept, created the better therapeutic relationship. He also stated, "Clinical experience, as well as experimental studies suggest that the quality of the relationship created between patient and therapist may also be a function of the particular aspects of their personalities and perceptions of each other" (p. 8).

Apfelbaum (1958) reports a series of studies which are particularly important as background for the present study. Specifically, his investigations were concerned with patients' strongly held expectations regarding the personalities of their prospective psychotherapists. The results which are of interest for the present study suggested a perseverance through therapy of the patients' expectations of their therapists (Q-sorts at the end of therapy were quite similar to those at the beginning. The Q-sorts also represented to some degree realistic descriptions of the therapists). Further, expectation clusters were associated with interpersonal expectations which were related not only to general personality functioning of the patients, but also to the subsequent character of the patient-therapist relationship.

Except for Parloff's, the previously mentioned studies have been concerned with the characteristics which might affect the individual's therapeutic relationships in general. It was suggested that the listed factors would enhance the probability of a good relationship between the patient and therapist and lead to a generally favorable outcome. However, it has been suggested further that many of the important variables in psychotherapy are to be found in the study of the individual interactions. Fiedler's (1951) findings encouraged speculation that some characteristics of the individual interaction and relationship might be more important in determining outcomes than theoretical orientation or even extent of training of the therapist. Others have suggested that a therapist might work well with one patient, or with patients of similar personality structures, cultural backgrounds, etc., but not with others. Strupp (1962) states, "an important contribution of research along these lines would be improved ability to predict the course and outcome of psychotherapy for a particular patient with a particular therapist."

The ensuing studies have been referred to as "goodness of fit" studies because they emphasize the importance of a "fit" between the personality of the therapist and the personality of the patient. Studies of the goodness of fit of therapist and patient are represented by Heine and Carson (1962). Their work showed that the respective personality patterns of the patient and therapist as measured by the MMPI should not be too similar or too dissimilar for the most effective outcome. In his study on authoritarianism in the

therapeutic relationship, Vogel (1959) has suggested that similarity with respect to attitudes of patient-therapist pairs would enhance their degree of satisfaction with the relationship. Rosenthal (1955) has shown that patients who improved in therapy tended to revise certain of their moral values in the direction of the therapist's values. Each of these studies seems to suggest that the interaction of the patient's and therapist's personalities, and their relative appropriateness to each other would have a significant effect upon the process of psychotherapy.

Leary (1957) and Snyder (1961) have made extensive attempts to provide a more scientific basis for patient therapist pairings. Leary's work began with a basic aim of study of "process in psychotherapy." However, it was considered a necessary step prior to process study to construct a systematic way of viewing personality structure before therapy. An objective detailed analysis of personality on a number of levels was made. Leary presents a system with many diagnostic and prognostic features. However, the major situation about which predictions were to be made was the interaction of a patient with a therapist. One of his primary goals was the assignment of patient and therapist in a fashion that would bring about the most effective and efficient therapeutic result. It was thought that this might be achieved through a matching based upon need oriented diagnostic testing of patient and therapist with the measures selected.

Snyder (1961) reported the results of a four year research project in his book, The Psychotherapeutic Relationship. Twenty patients were seen by one therapist during the course of psychotherapy. The

subjects, with one exception, were graduate students in psychology. Both therapist and patient were extensively tested and rated before, at selected intervals during, and after therapy on personality patterns, preferences and affect toward each other. These data were then analyzed in terms of the relation of patient to therapist profiles and to the outcome of therapy. Snyder concludes,

> To us it seems that relationship is a basic component of therapy. Without it, techniques are of little value. When client and therapist are *properly matched*,* they can develop an effective interpersonal and therapeutic relationship which is quite reciprocal in character, and which grows increasingly positive, making an effective therapeutic outcome probable. With more knowledge, *it should be possible to determine at the beginning of therapy which clients and therapists are best suited to each other, and most likely to be able to establish a therapeutic relationship*. At that point, therapy will have taken a large step in the direction of science, and will be less dependent upon the art of the therapist. (p. 367)

There is support then for the notion that their relationship may be significantly affected by the relative compatibility of needs of the patient and therapist. Earlier the importance of the patient's expectations of the therapist for their relationship was brought out. These concepts could be combined in the following way: the compatibility of the individual patient's needs with the needs of the individual therapist *as perceived by the patient* would be related to the patient's expectations about the relationship at the beginning of therapy. These expectations, in turn, would be related to the relationship that was established and to the eventual outcome. The present study is an investigation of the relations between the compatibility of the patient's needs with the therapist's needs as perceived by the

---

*italics inserted

patient and the patient's expectations for therapeutic outcome.

Development of Hypotheses

Hypothesis I

Research with the PIT (Chambers & Broussard, 1960a, 1960b) (Currier, 1963) and everyday experience suggests that if a person values a particular need he will feel positively toward people whom he perceives as having that need. And if he attaches a negative value to a need, he will generally feel negatively toward those he perceives to have the need. Thus it seems likely that a patient will generally seek a relationship with a therapist whom he perceives as having the same values as himself, and that he will have favorable expectations of this relationship.

It is hypothesized that the patient will have a more favorable expectation of outcome with a therapist as his needs are perceived to be more similar to the most highly valued needs of the patient.

Hypothesis II

Another variable which is seen to be important for the patient's perceptions of and interactions with the therapist is his relative level of conflictedness about his own needs. Apfelbaum (1958) has noted that the patient's level of maladjustment significantly affects the relationship and eventual outcome of therapy. In many respects the level of maladjustment might be equated with the patient's degree of conflictedness in achieving satisfaction of his needs. For the purpose of this study, the patient who cannot combine his needs so as to

achieve satisfaction of a number of needs at the same time is considered to be conflicted about his needs and to experience a high level of maladjustment. Whereas the patient who can combine needs so as to achieve satisfaction of a number of needs at the same time is seen to be less conflicted and to have a lower level of maladjustment. It seems plausible that the patient's degree of conflictedness about his needs will affect his expectations for therapeutic outcome with a particular therapist. A patient may positively value certain needs, but be conflicted about them so that he will avoid a relationship with another person whom he perceives as also having strong needs the same as his own conflicted ones. For example, a patient with strong needs for autonomy, dominance, and aggression, who is conflicted about these needs seems unlikely to seek a relationship with another person whom he perceives as having strong needs for autonomy, dominance and aggression. He is likely to seek a therapist whose perceived need structure is different from his own. This may be because he seeks easy expression of his own needs and avoids the competition for need satisfaction, or he may want to avoid the arousal of anxiety and discomfort in perceiving those needs in the therapist and thus have to deal with them at some level in their interaction.

It is hypothesized that the patient's level of conflict about his highly valued needs will differentially affect his expectation of outcome with a particular therapist:

<u>The patient with high conflict about his highly valued needs will have a more favorable expectation of outcome</u>

with a therapist as he perceives the therapist's needs to be different from his own; the patient with low conflict about his highly valued needs will have a more favorable expectation of outcome with a therapist as he perceives the therapist's needs to be similar to his own.

Hypothesis III

In addition to those findings which suggest that patient-therapist need structures should be similar, and those which suggest that difference is desirable, some investigators have suggested that the respective need-structures should be complementary or reciprocal in nature for the most effective relationship. Leary (1957), Snyder (1961), and Apfelbaum (1958) have made suggestions to this effect. Snyder noted in his extensive study that there was a tendency for poorer clients to be more like the therapist at the beginning of therapy, particularly in their high needs for independence. The four clients least like the therapist at the beginning of therapy were the four cases ranked as most successful during treatment. He concludes,

> We see in these facts some evidence for the concept of a desirable reciprocity of personality between client and therapist, or as Leary has suggested that individuals tend to "pull" from others responses opposite from their own. At least, it appeared in our study, that the therapist and client had a better relationship when their need structures tended to complement each other, rather than be similar. A symbiotic type of relationship is suggested here. (p. 356)

Schutz (1958) in his book FIRO has made an important contribution to this area with his three dimensional theory of interpersonal

behavior. He has attempted a clarification of interpersonal behavior theory which includes considerable explanation of reciprocal or complementary needs. The central concept used in this theoretical explanation of the interaction of the individuals is "compatibility." "Compatibility is a property of a relation between two or more persons ..., that leads to mutual satisfaction of interpersonal needs and harmonious coexistence" (p. 105). Reciprocal compatibility exists when the expressed behavior of one member of a dyad equals the wanted behavior of the other member, and vice versa. Each individual is seen as desiring a certain optimal relation between himself and others in each need area.

Applying this thinking to the present study's focus on the patient's needs and his perceptions of the therapist,

> it is hypothesized that a patient will have a more favorable expectation of outcome of therapy for a therapist as he is seen as needing to express what the patient needs to receive.

Hypotheses to be Tested

General statement

A patient's expectation of outcome of therapy with a particular therapist can be related in some systematic and predictable ways to relations between the patient's own need structure and his perception of the therapist's needs.

Some specific hypotheses about the relationships between patient's need patterns, his perceptions of the therapist's needs and the patient's expectation of therapeutic outcome are:

Hypothesis I.—Patients will have a more favorable expectation of therapeutic outcome with a therapist as his needs are perceived to be more similar to the most highly valued needs of the patient.

Hypothesis II.—The patient's level of conflict about his most highly valued needs will differentially affect his outcome expectation with a therapist, depending upon his perception of the therapist as having needs similar or dissimilar to his own.

1. The patient who has high conflict about his most highly valued needs will have a more favorable expectation of outcome in psychotherapy with a therapist as he perceives the therapist's needs to be different from his own.

2. The patient with low conflict about his most highly valued needs will have a more favorable expectation of outcome in psychotherapy with a therapist as he perceives the therapist's needs to be similar to his own.

Hypothesis III.—A patient will expect a more favorable outcome in psychotherapy for a therapist as he perceives him as having needs reciprocal to his own. A more favorable expectation for outcome will be held as the therapist is perceived as needing to express what the patient needs to receive.

CHAPTER II

METHOD

Subjects

Subjects were 42 male university students secured from both the Mental Health Unit at the University of Florida Infirmary and from the Counseling Center of the University of Florida. They ranged from 18 to 31 years of age with a mean of 21.66 years. Only five were over 25 years of age. The subjects were students who had applied for help with personal problems but had not begun treatment at the time of the study. Two measures of the patients' needs were taken first. They then viewed films of three therapists in action with the same patient. After each film each patient completed a form indicating his perception of each therapist's needs, and a form indicating his expected feelings about the relationship after therapy with each therapist. Finally, after the films had been seen, the patients were asked to rank the therapists in terms of the most favorable, second favorable, and least favorable expectations for psychotherapeutic outcome. The instructions to the patients and a detailed sequence of procedure administration appear in Appendix A. Only male patients were used since some studies have reported differences in therapeutic relationships depending upon whether the therapist and patient were of same or opposite sexes, Currier (1963) and Apfelbaum (1958). It also seemed important to exclude from the study those people who had previous experience with psychotherapy, those who had

previous acquaintance with any of the therapists in the films, and foreign born students who presented some problems in language communication.

Measures of Patient's Needs

Picture Identification Test (PIT)

A measure of the patient's dominant needs and need structure was derived from the scores on the PIT (Chambers, 1958). This instrument is not commonly used in clinical practice, but seems to be a promising objectively scored projective personality inventory for use in many areas of clinical practice and research. There are two forms, Male and Female. The test material consists of six plates of photographs of same sex persons, ages 18-20, taken from college annuals. Six pictures are included on each plate. In Part One of the test, the _S_ is asked to select the two people from each plate he would like best as friends or people, just by what he can see in the picture. Then, he is asked to select two from each plate he feels he would like least.

Part Two consists of six pages, one for each plate of pictures. Each page has 21 statements, and each statement refers to a need in the Murray Need System. The subject is asked to indicate which picture he feels best fits the "personality description" represented by the statement. Within the 126 statements, there is a repetition of 63 basic statements.

Scoring is done with the IBM 101, 650, or 709. Three dimensions of needs can be derived as a result of three separate scoring

operations. These dimensions are (1) stanine Attitude (A) scores, (2) stanine Judgment (J) scores and (3) stanine Association Index (AI) scores, for each of the 21 needs. The (A) Attitude scores and the (AI) Association Index scores were used in this study. As in the Currier study (1963), PIT Attitude Scores (A) were treated conceptually as "values." These scores were derived from a summing of the number of times a particular set of need statements were associated with "like best" pictures. A need frequently associated with "like least" pictures was assumed to be devalued. A high stanine score represented a need which was positively valued to a greater degree than the norm group and a low stanine score represented a need which was devalued to a greater degree than the norm group. For this study, the highly valued needs of the patient were those needs which received an attitude or value rating which fell in the 5th, 6th, 7th or 8th stanine category. A copy of the patients' Attitude Scores for this study appears in Appendix B.

A PIT Association Index (AI) score for a need was considered an indicator of conflict regarding that need, as was done in the Currier study. This score was derived from the degree to which the subject's <u>need combinations</u> coincided with the norm group. A low score indicated that he combines needs differently from the norm group. If a person evidenced an idiosyncratic pattern of need combinations, as shown by his low (AI) score, this was considered conflict about the need. It was inferred that he is unable to combine the need effectively or to integrate it adequately into his personality. A high (AI) score was interpreted as indicating relatively little conflict

about a need. A copy of the patient's Association Index scores for this study appears in Appendix C.

Norms, Reliability and Validity.—Size of the norm groups has varied for the different types of scores, but there were never fewer than 200 cases for the college student norm groups. An analysis of the Judgment choices of 600 adult females showed an average correlation of +.89 with those of college women. Test-retest reliability with an interval of two months showed a correlation of +.70 for Judgment choices and +.73 for the Association Index. These results were similar to those obtained by Chambers (private communication quoted by Currier), who found reliability coefficients for each of the 21 needs, to be "around +.50, while coefficients for patterns were around +.80." (1963).

This test had been administered as part of the Orientation Testing Program at the University of Florida in February, June and September, 1962. Norms are being evolved, based on a sample of 2400 students. The male Judgment tables on this sample correlated +.93 with those reported by Chambers. The present study will use Chambers' norms.

In an early study of validity, Chambers (1957) used the PIT and the GAMIN, and found that college students' results indicated significant correlations among several measures of attitudes. The high agreement between the self ratings and the objective tests was interpreted as support for the concept of identification with the pictures used to measure attitudes on the PIT.

Two other validity studies by Chambers and Broussard (1960a)

(1960b) investigated the need patterns of normal adult males and hospitalized veterans. Intercorrelations between groups of needs and cluster analyses were done. Significant differences were found between the normals and the patients, thus verifying the importance of the associations or clusters. This relates to the Association Index measure.

Fundamental Interpersonal Relations Orientation-Behavior (FIRO-B)

This test was used to measure further aspects of the patient's need structure. The FIRO-B is a test devised by Schutz (1958) and was designed to measure an individual's orientation to the interpersonal needs of inclusion, control and affection. The primary purposes for its construction were (1) to have a measure of how an individual acts in interpersonal situations and (2) to have a measure that will lead to the prediction of interaction between people, based on data from the measuring instrument alone. It was designed to measure the individual's desires to express behavior toward others (e) and his desires for behavior from others (w) in the three areas of interpersonal interaction; inclusion, affection and control. Each of the six scores was derived from a separate scale which was composed following the Guttman (1950) technique for cumulative scale analysis. Subjects are assigned scale scores (1 to 9) equal to the number of items accepted. Thus, there are six scale scores, one for each area, expressed inclusion behavior (e^I), wanted inclusion behavior (w^I), expressed control behavior (e^C), wanted control behavior (w^C), expressed affection behavior (e^A), and wanted affection behavior (w^A). The wanted dimension of interpersonal needs for the subjects was of major

interest in formulating the hypotheses for the present study. A copy of the patients' FIRO-B Scaled Scores appears in Appendix D.

Norms, Reliability and Validity.—The original scales were developed on 150 Ss gathered from the Boston area colleges and military units. A cross-validation study was done on 1500 Ss, primarily from Harvard, Radcliffe, Harvard Business School and other colleges in the Boston area. Since the split-half method is not appropriate to the Guttman type scales, reproducibility was the appropriate measure of internal consistency. The coefficient of internal consistency calculated in this way over the six sub-scales yielded a mean of +.94, with a low of +.93 and a high of .+94. A coefficient of stability, test-retest reliability, with a one-month interval showed a mean correlation of +.76, with a low of +.71 and a high of +.82 over the six sub-scales.

Each of the many studies presented in Schutz's book may be considered relevant to predictive validity. Some studies show significant differences in the interpersonal character of various jobs and choice of occupation. For example, Business School students were found significantly higher than Harvard and Radcliffe freshmen on controlling and influencing others. In the desire to have extensive relations with people, they scored significantly higher than the freshmen.

Another area in which data supported the concurrent validity of FIRO-B was that of political attitudes. Using the FIRO-B and constructed political questionnaires, McElheny (1957) compared the interpersonal orientations of the subjects with differing political

attitudes and found significant relationships (.05 level or better for the individual predictions, and less than .01 for the combined predictions), which would discriminate individuals with divergent political attitudes. Other studies by Bunker (1957) and Cohen (1957) have shown significant relations between interpersonal orientations on the FIRO-B and conformity behavior situations.

Conversion of PIT Scores to FIRO-B Scores

Since it was planned to compare the behaviors the patients "wanted" with their perceptions of the behaviors the therapists needed to express, it was necessary to devise a method for converting the 21 PIT Needs to wanted behaviors in the three FIRO-B categories. This conversion was done in the following way: the definitions of the 21 PIT Needs as contained in the PIT Manual for Subjects (Chambers, 1958) were compared with the definitions for each of the three need areas of the FIRO-B (Schutz, 1958). Each of the PIT Needs was then placed into one of the three FIRO-B categories on the basis of what appeared to be the most crucial behavioral dynamic of the definition. For example, the need to dominate was seen to involve primarily the behavior of attempting to control others and was classified under the FIRO-B Control Needs. In a similar manner, the need for affiliation appeared primarily to involve a general need for Inclusion. Similarly, the need of nurturance seemed to involved primarily Affection Needs. Some needs, as the ones mentioned above, were quite easy to place into FIRO-B categories. A few needs such as PIT Need #12 Harm Avoidance, #19 Sex, and #11 Exhibition were not as simple to categorize. A chart showing the conversions appears in Table 1.

Table 1

PIT to FIRO-B Conversion Table

FIRO-B Needs		
INCLUSION	AFFECTION	CONTROL
PIT Needs		
# 3 Affiliation	# 1 Abasement	# 2 Achievement
# 6 Blame Avoidance	# 8 Deference	# 4 Aggression
#12 Harm Avoidance	#14 Nurturance	# 5 Autonomy
#13 Inferiority Avoidance	#18 Sentience	# 7 Counteraction
#16 Play	#19 Sex	# 9 Defendance
#17 Rejection	#20 Succorance	#10 Dominance
		#11 Exhibition
		#15 Order
		#21 Understanding

Measures of Therapist's Needs as Perceived by Patients

Separate films of the three individual therapists in action with the same client were taken from a series of counseling films already available at the University of Florida. Gollin (1960) used a movie presentation to study the forming of impressions of personality. He states regarding moving picture presentations, "Information about social perception may be obtained by a variety of methods, but it is likely that the most productive methods will be those which attempt to retain the rich and varied stimulus properties of persons while exercising

optimal experimental control over the judgment producing situation... the use of motion pictures provides an excellent vehicle for achieving these methodological goals." (1960, p. 161.)

The therapists and the patient in the films are all males with PhD's in Clinical Psychology with at least five years experience as counselors or psychotherapists. They ranged in age from 38 to 52. The films are from 20-28 minutes long. From five films that were available, three were used in this study. They were selected on the basis of the therapist characteristics which most closely approximated the three therapist types which were pre-conceived by Apfelbaum's (1958) patients. They were also selected for diversity of therapist characteristics on the basis of ratings done by five graduate students in psychology. A ten-minute segment from each film was selected for presentation. Presentation of therapist films to the subjects was systematically varied as follows: ABC, BCA, CAB, ACB, BAC, CBA to control for possible sequential effects.

PIT Behavior Rating Scale (BRS)

This test was devised by the author to measure the patient's perceptions and impressions of the therapists' need structures. This was achieved by securing ratings on the behavior description statements from Part II of the PIT. A copy of this form and the instructions given to the patients appears in Appendix E . Each of the 21 statements refers to a need in the Murray System, and was selected from three possible statements as best representing that particular need. The patient was asked to rate each therapist on each statement on an eight point rating scale indicating the degree to which a particular

need behavior was perceived as characteristic of a given therapist. The scales for each therapist were completed immediately after the film in which he was portrayed, to prevent overlap or confusion of impression. A copy of the BRS Scores attributed to the therapists in this study appears in Appendix F.

Reliability.—An important question affecting the outcome of this study was related to the problem of the consistency or reliability with which the needs were attributed to a given therapist, and also that some needs may be rated high or low more consistently than others. If the needs were not rated consistently high or low to a given therapist, though they may vary between therapists, it would be difficult to draw meaningful conclusions regarding the impressions formed. It was important that they be related to stable impressions of personality characteristics of the therapist, rather than momentary feelings or impressions.

A study was made of the reliability of patient perceptions of the therapists. This was done through the construction of an alternate form to the original measure. The alternate form was constructed by using 21 additional behavior description statements from Part II of the PIT, one for each of the 21 needs. These statements were presented at the same time as the original and scored in the same way. A copy of this form appears in Appendix E. The original form occupies the first page of the Behavior Rating Scale, and the alternate form is on the second page. The original and alternate forms were used to rate each therapist. Two measures of consistency were computed. Firstly, it was possible to determine the degree of consistency with which the needs were assigned

to the individual therapists. The correlation between the original and alternate form ratings for each therapist indicated the strength of the tendency for the needs to be consistently rated for a particular therapist. The correlations for the three therapists appear in Table 2. The correlation of the ratings of Therapist B's needs between the original and alternate forms for all needs by all subjects was .642, for Therapist C .618 and for Therapist A .59. And secondly, correlations were computed to determine the consistency with which each of the 21 needs was rated high or low for any therapist. Table 3 shows the correlations between the original and alternate forms for each of the 21 needs, therapists combined. They range from a correlation of .757 for need #2 (Achievement) to an R of .307 for need #3 (Affiliation).

Table 2

Reliability of Patients' Perceptions of Therapists
(on PIT) Needs Using Alternate Rating Forms

Needs by all Ss

Therapists	Pearson r
Therapist A	.590
Therapist B	.642
Therapist C	.618

Table 3

Reliability of Patients' Perceptions of Therapists on PIT Needs

Need	Pearson r	Need	Pearson r
# 1 Abasement	.415	#11 Exhibition	.558
# 2 Achievement	.757	#12 Harm Avoidance	.488
# 3 Affiliation	.307	#13 Inferiority Avoidance	.629
# 4 Aggression	.522	#14 Nurturance	.395
# 5 Autonomy	.466	#15 Order	.675
# 6 Blame Avoidance	.419	#16 Play	.707
# 7 Counteraction	.741	#17 Rejection	.565
# 8 Deference	.605	#18 Sentience	.518
# 9 Defendance	.549	#19 Sex	.737
#10 Dominance	.530	#20 Succorance	.493
#21 Understanding	.647		

Measures of Patient's Expectations for Outcome

Semantic Differential

A Semantic Differential Scale was presented after each film. A copy appears in Appendix G. This scale, based on Osgood's findings (1957), was used to obtain a measure of the patient's anticipated feelings about the therapeutic relationship after psychotherapy with each therapist. It also provided a comparison to the actual rankings of the therapists. The word pairs were selected from the listings of Osgood to include the highest pure factor loadings. Only scores on the Evaluative and Potency Factors were used in the present study.

Rankings

After viewing the three films the patients were asked to indicate their expectations for therapy outcome by ranking and comparing the three therapists in two ways. A copy of this form and instructions appears in Appendix H. Patients ranked therapists, listing first the therapist for whom the most favorable expectation was held; second, the therapist for whom the next most favorable expectation was held; and third, the therapist for whom the least favorable outcome was expected. Next, they were asked to compare the therapists and rate them on a four point scale on the degrees of difference they perceived between the therapists. A copy of the Actual Rankings and the rankings as determined by the Semantic Differential Factors E and P appears in Appendix I.

Comparisons Between Semantic Differential and Actual Ranking

The mean factor scores for each therapist on each of the Semantic

Differential factors were placed in one of three columns, for the most preferred, second preferred, or least preferred therapist as based upon the actual rankings. T-tests were then determined on the differences between the means of the distributions. These analyses for both the Evaluative and Potency Factors appear in Table 4. All six of the tests are significant beyond the .01 level. There were significantly higher mean factor scores on both factors for the most preferred therapist than for the second and least preferred therapists. There were also significantly higher mean factor scores on both factors for the second as compared with the least preferred therapists.

Table 4

Differences between Mean Scores on Semantic Differential Factors for the Most, Second and Least Preferred Therapists

SEMANTIC DIFFERENTIAL EVALUATIVE FACTOR E			
Therapist	$\bar{X}$	Analysis	t
X Most Preferred	1.56	x with y	4.92**
Y Second Preferred	.76	x with z	9.68**
Z Least Preferred	−.11	y with z	4.54**
SEMANTIC DIFFERENTIAL POTENCY FACTOR P			
Therapist	$\bar{X}$	Analysis	t
X Most Preferred	1.45	x with y	4.59**
Y Second Preferred	.62	x with z	9.38**
Z Least Preferred	−.27	y with z	4.15**

**P $< .01$ level

Testing of Hypotheses

Hypothesis I

Patients will have a more favorable expectation of therapeutic outcome with a therapist as his needs are perceived to be more similar to the most highly valued needs of the patient. Comparisons were made between the scores of the highly valued needs of the patient (5th, 6th, 7th, and 8th stanine Attitude scores on the PIT), and each therapist's scores for the same needs on the PIT Behavior Rating Scales. Discrepancy scores were computed between the high ratings of the patient's needs and his high or low ratings of the therapists for each of those needs. The Behavior Rating Scales were designed with an eight point rating range to make possible an easier comparison with the stanine scores of the PIT. A high discrepancy between a patient's score and the therapist's score would indicate a difference in need structure; whereas a low discrepancy score between patient and therapist need scores would indicate a similarity between the highly valued needs of the patient and those needs seen as characteristic of the therapist. Thus, high discrepancy means difference, and low discrepancy means similarity.

The discrepancy scores for each of the patient's highly valued needs were summed and divided by the number of highly valued needs. This resulted in a mean discrepancy score for each patient-therapist pair. This score was assumed to be an indication of the degree of similarity or difference, the "fit" between the most highly valued needs of the patient and his ratings of the therapists on those needs. The mean discrepancy scores were placed in one of three columns, for the

most preferred, second preferred, or least preferred therapist as determined by the actual rankings. A second ranking of the therapists was achieved by using the semantic differential mean factor scores. The highest factor score was assumed to indicate the most preferred therapist, the second highest score, the second preferred therapist, and the lowest factor score for the least preferred therapist. Analyses were done for both the Evaluative and Potency Factors.

Operationally, Hypothesis I predicted that the mean discrepancy scores would be lowest for the most preferred therapist, next lowest for the second preferred therapist, and highest for the least preferred therapist.

Hypothesis II

The patient's level of conflict about his most highly valued needs will differentially affect his expectation of outcome with therapists.

1. The patient with high conflict about his most highly valued needs will have a more favorable expectation of outcome in psychotherapy with a therapist as he perceives the therapist's needs to be different from his own.

2. The patient with low conflict about his most highly valued needs will have a more favorable expectation of outcome in psychotherapy as he perceives the therapist's needs to be similar to his own.

As stated earlier, each need for each patient received both an Attitude Score (treated conceptually as valued), and an Association Index Score (treated conceptually as conflict indicator). A high

Association Index Score for a particular need meant relatively low conflict about the need, and a low Association Index Score means relatively high conflict about a particular need. Only the Association Index Scores for the most highly valued needs were used in the analysis. These scores were then compared with the scores attributed to each therapist for those needs. Discrepancy scores were then computed for each need and averaged for each patient-therapist pair, yielding a mean discrepancy score as in Hypothesis I.

The patients were then divided into high and low conflict groups and these were analyzed separately. The division was done in the following way: the sum of a patient's individual Association Index scores for highly valued needs was divided by the number of needs involved to obtain a mean Association Index Score. This score was assumed to indicate a general level of conflictedness about the patient's most highly valued needs. The mean Association Index scores were ranked from highest to lowest and then divided at the midpoint of the distribution into High and Low Conflict Groups. It was assumed that the group having high mean AI scores were relatively less conflicted about their most highly valued needs than the group having lower AI scores.

A low mean discrepancy score for the most preferred therapist of a low conflict patient (High AI score) was assumed to mean that the patient who was relatively less conflicted about his highly valued needs had sought a relationship with a therapist who was characterized by those needs and thus similar in need structure to the patient. Whereas, a low mean discrepancy score for the most preferred therapist of

a high conflict patient (Low AI score) was assumed to mean that the patient had sought a relationship with a therapist who was not characterized by those needs and thus different in need structure from the patient.

Operationally, the discrepancies between the AI scores of the patient for his highly valued needs, in both the High and Low Conflict Groups, and his ratings of the therapist on those needs would be lowest for the most preferred therapist and highest for the least preferred therapist.

Hypothesis III

A patient will expect a more favorable outcome with a therapist as he perceives him as having needs reciprocal to his own. A more favorable expectation for outcome will be held as a therapist is perceived as needing to express what the patient needs to receive.

Comparisons were made between each patient's FIRO-B scaled scores for wanted behavior from others translated into his most highly valued PIT needs and the patient's ratings of each therapist on those needs from the BRS. The translation was done in this manner since the crucial factor in the analysis of this hypothesis was the degree that a particular valued PIT need behavior was wanted by the patient. This permitted comparison between the degree of the patient's desire for satisfaction of a given need and his perception of a particular therapist's likelihood of fulfilling that need. The conversion from the FIRO-B wanted score to the PIT needs was done in the following way. If the wanted dimension of the Inclusion Needs of the FIRO-B received a score of 6, then each of the PIT Needs which was regarded as Inclusion

Needs (conversion formula in Table 1) also received a score of 6. The Affection and Control Needs were also handled in the same way.

The discrepancies between the patient's score and those of the therapists were computed in the following way. Since the patient's wanted score for a given need ranged from 1 through 8, it was assumed in this study that a patient score of 4 or lower on a need indicated a low desire for that behavior from others. A patient score of 5 or above was considered as indicating a high desire for a given behavior from others. Thus, it was assumed that a patient with a low desire for a particular behavior would have a more favorable expectation of therapeutic outcome in a relationship with the therapist who was perceived as at least having that need. Likewise, a patient with a high desire for a particular behavior would have a more favorable expectation with the therapist who was perceived as most possessing that need.

For example, if patient X's wanted score for Need #4 was 3, and the scores for the therapists were Therapist A, 4; Therapist B, 2; and Therapist C, 5, patient X would have the most favorable expectation for Therapist B. Therapist B would receive a discrepancy score of 0, Therapist A, 2, and Therapist C, a score of 3. If patient Y's wanted score was 7 for Need #4, and the therapists' scores were Therapist A, 8, Therapist B, 3, and Therapist C, 7; patient Y would have the most favorable expectation for Therapist A. Therapist B would receive a discrepancy score of 5, and Therapist C a score of 1. The therapist for whom the most favorable expectation was held received a discrepancy score of 0, and the other therapists' scores were based upon their numerical distance from the score of the most preferred therapist.

CHAPTER III

RESULTS

The results of the study will be reported in relation to the hypotheses that were tested.

Hypothesis I stated that a patient would have a more favorable expectation of outcome with the therapist whose perceived needs were similar to his own most highly valued needs. Operationally, it suggested that the discrepancy scores would be lowest for the most preferred therapist, somewhat higher for the second preferred therapist, and highest for the least preferred therapist. The attitude scores for each patient's most highly valued needs were compared with his ratings for each of the therapists on the same needs as described in Chapter II. Discrepancy scores, after being computed and averaged, yielded a mean discrepancy score for each patient-therapist pair. These mean discrepancy scores for each pair were then placed in columns for most, second, and least preferred therapist as determined by the actual rankings by the two Semantic Differential Factors, Evaluative (E) and Potency (P). For the Semantic Differential criteria, the therapist with the highest mean factor loading was assumed to be the most preferred, the therapist with the second highest factor loading was considered the second preferred, and the therapist receiving the lowest factor loading was considered the least preferred.

Table 5 shows the means for each distribution and the t-tests

Table 5

Differences between Mean Scores for Discrepancies between Patients Value Ranking of Own Needs and of Therapist Needs

N = 42

Therapist	$\bar{X}$	Analysis	t
ACTUAL RANKING			
X Most Preferred	1.79	x with y	.13
Y Second Preferred	1.80	x with z	2.08*
Z Least Preferred	1.90	y with z	1.79
SEMANTIC DIFFERENTIAL FACTOR E			
X Most Preferred	1.76	x with y	.96
Y Second Preferred	1.86	x with z	1.80
Z Least Preferred	1.94	y with z	.72
SEMANTIC DIFFERENTIAL FACTOR P			
X Most Preferred	1.78	x with y	.40
Y Second Preferred	1.82	x with z	2.07*
Z Least Preferred	1.98	y with z	1.55

*$p < .05$

for the differences between the means. The two significant relationships ($P < .05$) indicate significantly lower discrepancy scores for the most preferred than for the least preferred therapist on the actual rankings and for the Semantic Differential Factor P. The t-test for the Semantic Differential Factor E between the mean of the most preferred and the least preferred therapist is suggestive of a similar trend, but is not significant. In each of the analyses, the means are in the predicted direction for all therapists with the lower mean scores associated with the most preferred, the next highest means for the second preferred, and the highest mean for the least preferred therapist. No significant relationships were found between the means of the first and second preferred therapists, nor between the means of the second and least preferred therapists.

Hypothesis II stated that the patient's degree of conflict about his most highly valued needs would differentially affect his outcome expectation for different psychotherapists in the following ways: (1) the patient with high conflict about his most highly valued needs would have a more favorable expectation for outcome with a therapist of different need structure, and (2) the patient with low conflict about his most highly valued needs would have a more favorable expectation for outcome with a therapist of similar need structure. The Ss were divided into High Conflict and Low Conflict Groups as described in Chapter II. It was predicted that the discrepancy scores for both groups would be lowest for the most preferred, next highest for the second preferred, and highest for the least preferred therapist. Analyses were done using both the actual rankings and the Semantic Differential

factors as criteria.

T-tests on the differences between the mean discrepancy scores for each of the therapists for the Low Conflict Group appear in Table 6, and for the High Conflict Group in Table 7. These differences were not statistically significant. However, the lowest discrepancies were associated with the least preferred therapist in every analysis for both the Low and High Conflict Groups, and the highest discrepancies were associated with the most preferred therapist in one of three cases with the Low Conflict Group with all three cases in the High Conflict Group. Further analyses were also done on the devalued needs for both the Low and High Conflict Groups. These analyses are presented in Tables 8 and 9. These results were also insignificant. However the lowest discrepancies were associated with the least preferred therapist in two out of three cases for the Low Conflict Group and for all three cases in the High Conflict Group. The highest discrepancies were associated with the most preferred therapist in all six instances. Combined, these data show the lowest discrepancies associated with the least preferred therapist in 11 of 12 possible instances, and the highest discrepancies associated with the most preferred therapist in 10 out of 12 instances.

Hypothesis III stated that a reciprocity of need patterns of patient and therapist would be associated with patients' expectations of favorable outcome. Comparisons were made between the patient's wanted score as indicated on the FIRO-B and converted to PIT for a particular need and the scores attributed to each of the therapists for the same PIT need. T-tests on the differences between the mean

discrepancy scores for the first, second and least preferred therapists using the actual rankings and the Semantic Differential Factor Rankings appear in Table 10. These results suggest there are no non-chance variations in this sample as presented.

A further breakdown of these data was made using the method shown in Table 1. In order to permit a more specific analysis, the 21 needs of the PIT were separated into one of the three major need classifications as described by Schutz (1958); Affection, Inclusion, and Control.

Discrepancies were computed between the patient's wanted score and the score attributed to each therapist as in previous analyses. However, these raw discrepancies were then summed for the most, second and least preferred therapist according to the PIT Needs and these sums were placed into distributions based on the FIRO-B Need categories using the conversion chart presented in Table 1. All patients did not, of course, highly value the same needs or types of needs, thus there were unequal numbers of patients who contributed to each of the Need scores. The total discrepancy score for the most, second and least preferred therapist for a particular need was therefore divided by the number of patients who had contributed to that discrepancy and yielded a mean discrepancy score for each therapist for each need, patients combined. T-tests between the mean discrepancy scores of the Affective needs are presented in Table 11. These show no significant relationships and no consistent trends. T-tests for the Inclusion Needs are presented in Table 12. No significant relationships or trends are noted here.

Table 6

Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Valued Needs and Scores of Therapists' Needs

Low Conflict Patients

N = 21

Therapists	$\bar{X}$	Analysis	t
ACTUAL RANKING			
X Most Preferred	2.06	x with y	.21
Y Second Preferred	2.10	x with z	.81
Z Least Preferred	1.91	y with z	.93
SEMANTIC DIFFERENTIAL FACTOR E			
X Most Preferred	2.03	x with y	.30
Y Second Preferred	2.09	x with z	.43
Z Least Preferred	1.95	y with z	.68
SEMANTIC DIFFERENTIAL FACTOR P			
X Most Preferred	2.12	x with y	.78
Y Second Preferred	1.97	x with z	1.319
Z Least Preferred	1.88	y with z	.429

Table 7

Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Valued Needs and Scores of Therapists' Needs

High Conflict Patients

N = 21

ACTUAL RANKING

Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.84	x with y	.29
Y Second Preferred	1.80	x with z	.69
Z Least Preferred	1.74	y with z	.50

SEMANTIC DIFFERENTIAL FACTOR E

Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.87	x with y	.92
Y Second Preferred	1.75	x with z	.74
Z Least Preferred	1.76	y with z	.08

SEMANTIC DIFFERENTIAL FACTOR P

Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.85	x with y	.82
Y Second Preferred	1.77	x with z	.67
Z Least Preferred	1.76	y with z	.08

Table 8

Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Devalued Needs and Scores of Therapists' Needs

Low Conflict Patients

N = 21

ACTUAL RANKING			
Therapists	$\bar{X}$	Analysis	t
X Most Preferred	2.09	x with y	.71
Y Second Preferred	2.03	x with z	.86
Z Least Preferred	1.99	y with z	.58
SEMANTIC DIFFERENTIAL FACTOR E			
Therapists	$\bar{X}$	Analysis	t
X Most Preferred	2.02	x with y	1.21
Y Second Preferred	1.92	x with z	.98
Z Least Preferred	1.94	y with z	.42
SEMANTIC DIFFERENTIAL FACTOR P			
Therapists	$\bar{X}$	Analysis	t
X Most Preferred	2.06	x with y	.83
Y Second Preferred	1.97	x with z	1.18
Z Least Preferred	1.95	y with z	.37

Table 9

Differences between Mean Scores for Discrepancies between Patients' Level of Conflict Scores for Devalued Needs and Scores of Therapists' Needs

High Conflict Patients

N = 21

Therapists	$\overline{X}$	Analysis	t
ACTUAL RANKING			
X Most Preferred	2.02	x with y	.55
Y Second Preferred	1.92	x with z	.79
Z Least Preferred	1.88	y with z	.23
SEMANTIC DIFFERENTIAL FACTOR E			
X Most Preferred	2.08	x with y	1.30
Y Second Preferred	1.85	x with z	1.19
Z Least Preferred	1.88	y with z	.18
SEMANTIC DIFFERENTIAL FACTOR P			
X Most Preferred	1.98	x with y	.35
Y Second Preferred	1.92	x with z	.40
Z Least Preferred	1.91	y with z	.06

Table 10

Differences between Mean Scores for Discrepancies between Patients' FIRO-B Wanted Score Converted to PIT Needs and Scores of Therapists' Needs

N = 42

Therapists	$\overline{X}$	Analysis	t
ACTUAL RANKING			
X Most Preferred	.99	x with y	.364
Y Second Preferred	1.03	x with z	.018
Z Least Preferred	.97	y with z	.541
SEMANTIC DIFFERENTIAL FACTOR E			
X Most Preferred	1.04	x with y	.28
Y Second Preferred	1.01	x with z	1.00
Z Least Preferred	.93	y with z	.71
SEMANTIC DIFFERENTIAL FACTOR P			
X Most Preferred	1.002	x with y	.01
Y Second Preferred	1.000	x with z	.16
Z Least Preferred	.985	y with z	.13

Table 11

Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Affectional Needs with Individual Patient Scores Combined

N = 6

ACTUAL RANKING			
Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.02	x with y	.24
Y Second Preferred	.99	x with z	1.04
Z Least Preferred	.84	y with z	.88

Table 12

Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Inclusion Needs with Individual Patient Scores Combined

N = 6

ACTUAL RANKING			
Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.10	x with y	.27
Y Second Preferred	1.06	x with z	1.52
Z Least Preferred	.90	y with z	.86

T-tests between the means of the discrepancy scores for the control needs are presented in Table 13. There are no significant differences among the scores. The mean discrepancy score distribution for the control needs is presented in Table 14. The column totals and the entries for needs #4, #5, and #10, are in the predicted direction with the lowest mean discrepancy scores associated with the most preferred, the next highest scores with the second preferred, and the highest scores with the least preferred therapist. In five of nine instances the lowest discrepancies are associated with the most preferred therapist.

A further breakdown of the control needs was done by dividing the patients into two groups. As previously indicated (Schutz, 1958) each need received two scores; a score indicating the degree that the patient wanted to be acted toward in a given way, and a score indicating the degree that the patient wanted to express a behavior toward others.

Table 13

Differences between Mean Discrepancy Scores for the Three Therapists for FIRO-B Control Needs with Individual Patient Scores Combined

N = 9

ACTUAL RANKING			
Therapists	$\bar{X}$	Analysis	t
X Most Preferred	.87	x with y	.99
Y Second Preferred	1.04	x with z	1.53
Z Least Preferred	1.14	y with z	.41

In Group X were placed those patients whose wanted score for control was greater than their score for the need to express control over others. In Group Y were placed those patients whose wanted score was equal to or less than the score for the need to express control over others. Comparisons were then made among the discrepancy scores for the most, second and least preferred therapists for both groups. These data appear in Tables 15 and 16. The column totals for Group X Table 15 do not fall in the predicted direction. But they continue to show a tendency for the lowest discrepancy scores to be associated with the most preferred therapist (five of nine). In addition, it must be noted that the differences in the scores became more pronounced and more consistently in the direction of the lowest discrepancy scores being associated with the most preferred and the higher ones with the second and least preferred therapists. For example, when comparing scores in Table 14 with those in Table 15, the discrepancy scores for Group S, for the most preferred therapist became lower in six of nine instances, where as the discrepancy scores became higher for the second preferred therapist in eight of nine instances, and higher in six of nine instances for the least preferred therapist.

In Group Y, Table 16, the highest discrepancies are associated with the most preferred therapist in the column totals and for five of the nine individual needs. In addition, the comparison between Table 14 and Table 16 show that the discrepancy scores for the most preferred therapist became higher in five cases, remained the same in three cases, and became lower in one. Whereas the discrepancy scores

Table 14

Mean Discrepancy Score Distribution for the Three Therapists
for FIRO-B Control Needs
with Individual Patient Scores Combined

N = 9

Control Needs	Most Preferred Therapist	Second Preferred Therapist	Least Preferred Therapist	
# 2	1.15	.95	.45	
# 4	.91	1.55	1.64	
# 5	1.00	1.22	1.74	
# 7	1.26	.42	.74	
# 9	.63	1.69	1.56	
#10	.57	.86	1.33	
#11	.47	1.58	1.00	
#15	1.00	.58	1.05	
#21	.83	.63	.71	
ΣX	7.82	9.48	10.22	27.52
$\bar{X}$	.87	1.05	1.14	1.02

Table 15

Mean Discrepancy Score Distribution for the Three Therapists
for FIRO-B Control Needs
with Wanted Score Greater than the Expressed Score
and Individual Patient Scores Combined

Group X

N = 9

Control Needs	Most Preferred Therapist	Second Preferred Therapist	Least Preferred Therapist	
# 2	1.00	.88	.38	
# 4	.83	2.25	1.83	
# 5	1.00	1.27	2.09	
# 7	.88	.75	1.13	
# 9	.22	2.00	2.00	
#10	.43	1.43	1.00	
#11	.29	2.00	1.14	
#15	.90	.60	1.10	
#21	.85	.69	.69	
ΣX	6.40	10.43	9.54	26.37
$\bar{X}$	.71	1.15	1.06	.98

Table 16

Mean Discrepancy Score Distribution for the Three Therapists for FIRO-B Control Needs with Expressed Score Equal to or Greater than the Wanted Score and Individual Patient Scores Combined

Group Y

N = 9

Control Needs	Most Preferred Therapist	Second Preferred Therapist	Least Preferred Therapist
# 2	1.15	.92	.46
# 4	1.00	1.10	1.40
# 5	1.00	1.16	1.41
# 7	1.54	.18	.45
# 9	1.14	1.28	1.00
#10	.57	.50	1.50
#11	.58	1.33	.91
#15	1.11	.55	1.00
#21	.81	.54	.72
ΣX	8.90	7.56	8.85
$\bar{X}$	.98	.84	.98

became lower in all nine instances for the second preferred therapist, and lower in six of nine instances for the least preferred therapist.

An analysis of variance of the data in Table 15 appears in Table 17. A further statistical adjustment was required to permit this analysis. Each need score was contributed to by individual subject scores for that need. The individual subject scores on a particular need were recorded in the following manner. A zero score was given for the therapist who most fit (page 30, Chapter II) the patient's needs, and other scores were recorded according to their numerical distance from the score for the therapist most fitting the needs of the patient. For the present statistical analysis, an addition of one point was made to each score.

The F ratio of 4.74 with two and 249 df is significant beyond the .01 level. Table 18 shows the t-tests for all three criteria, the actual rankings, and Semantic Differential Factors E and P. Five of the nine tests are statistically significant, three beyond the .01 level and two beyond the .05 level. There were significantly lower discrepancy scores for the most preferred than for the second preferred therapist for the actual rankings ($P < .01$), and for the Semantic Differential Evaluative Factor ($P < .05$). There were significantly lower discrepancy scores for the most preferred than for the least preferred therapist for the actual rankings ($P < .01$), for the Semantic Differential Evaluative Factor ($P < .05$), and for the Semantic Differential Potency Factor ($P < .01$) when the wanted scores are greater than the expressed scores.

Table 17

Analysis of Variance of Adjusted Scores for Discrepancies between the Patients' FIRO-B Control Needs Converted to PIT Needs and Scores of Therapists' Needs When Patients' Wanted Score is Greater than the Expressed Score and Individual Patient and all Control Need Scores Combined

Group X

N = 84

Source	df	MS	F
Between	2	9.155	4.74*
Within	249	1.93	

*$P < .01$

Effect of Presentation Order of Therapist Films

The order of therapist film presentation was systematically varied in this study (as described in Chapter II) to control for the possible effect on the patient's ranking of therapists for favorable outcome by the preference order. Pairing of the order of presentation distribution with the order of preference distribution for each subject suggested that a possible relationship may be present. Since these data were in the form of frequencies a chi-square analysis was done. This analysis is presented in Table 19. A significant relationship ($P < .01$) was found between the order of therapist presentation and expectation of favorable outcome.

A comparison was then made of the frequencies with which each

of the three therapists A, B, and C were placed in the first, second, and third order of preference regardless of the presentation order. For example, Therapist A was most preferred only 3 times, second preferred 15 times and least preferred on 24 occasions; Therapist B was preferred most 11 times, second 20 times, and least preferred on 11 occasions; and Therapist C was most preferred 28 times, second preferred 7 times, and least preferred 7 times. A chi-square analysis of these data appears in Table 20. The chi-square of 40.70 is highly significant beyond the .01 level. The observed cell frequencies are significantly different from what would be expected purely on a chance basis.

The diagonal column starting from bottom left to top right suggests a definite ordering of the therapists in terms of their attractiveness or preferability to the patients; Therapist C, most preferred, Therapist B, second preferred and Therapist A, least preferred. These data were then divided into three chi-square tables showing the frequencies of preference of each therapist for each of the three possible presentation placements. This was done to determine if the significant trends noted might be related to a specific placement in the order of presentation, or whether the apparent preference for Therapist C was consistent regardless of the placement in the presentation order. The chi-square tables and analyses are presented in Table 21. The results show significance in all three presentations ($P < .05$ in the first presentation, $P < .01$ in the second and third presentations). The column totals for preference order suggest a trend toward avoiding the first presented therapist, whereas

Table 18

Differences between Mean Discrepancy Scores
for the Three Therapists for FIRO-B Control Needs
Converted to PIT Needs and Scores for Therapists' Needs
when Patients' Wanted Score is Greater than
the Expressed Score with Individual Needs Combined

N = 83

ACTUAL RANKING

Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.78	x with y	2.80**
Y Second Preferred	2.30	x with z	2.64**
Z Least Preferred	2.32	y with z	.11

SEMANTIC DIFFERENTIAL FACTOR E

Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.85	x with y	2.05*
Y Second Preferred	2.26	x with z	2.11*
Z Least Preferred	2.30	y with z	.17

SEMANTIC DIFFERENTIAL FACTOR P

Therapists	$\overline{X}$	Analysis	t
X Most Preferred	1.83	x with y	1.54
Y Second Preferred	2.14	x with z	2.89**
Z Least Preferred	2.44	y with z	1.32

*$p < .05$
**$p < .01$

Table 19

A Comparison of Presentation Order with Preference Order of Therapists

Order of Presentation	Preference Order 1	2	3
1	6	12	24
2	19	14	9
3	17	16	9

Expected Cell Frequency = 14

$$X^2 = \left[\frac{(f_o - f_e)^2}{f_e}\right]$$

$X^2 = 18.27^*$

df = 4

*p < .01 A chi-square value of 13.277 significant at the .01 level.

Table 20

A Comparison of the Preference Order and the Frequencies of Therapist Choice

		Preference Order			
		1	2	3	
Therapists	A	3	15	24	42
	B	11	20	11	42
	C	28	7	7	42
		42	42	42	

Expected Cell Frequency = 14

$$X^2 = \left[\frac{(f_o - f_e)^2}{f_e}\right]$$

$X_2 = 40.70$*

$X_2 = 4$

*P < .01

Table 21

Chi-Square Analyses of Individual Therapist Preference for Each Presentation

FIRST PRESENTATION

Preference Order

Therapists	1	2	3
A	0	3	11
B	0	6	8
C	6	3	5
	6	12	24

$$X^2 = \left[\frac{(f_o - f_e)^2}{f_e}\right]$$

$X^2 = 10.61$*

df = 4

SECOND PRESENTATION

Preference Order

Therapists	1	2	3
A	0	7	7
B	8	4	2
C	11	3	0
	19	14	9

$$X^2 = \left[(f_o - f_e)^2\right]$$

$X^2 = 15.58$**

df = 4

THIRD PRESENTATION

Preference Order

Therapists	1	2	3
A	3	5	6
B	3	10	1
C	11	1	2
	17	16	9

$$X^2 = \left[\frac{(f_o - f_e)^2}{f_e}\right]$$

$X^2 = 14.35$**

df - 4

*$p < .05$
**$p < .01$

this trend is reversed for the second and third presentations.

In addition to the above cited results, the data and analyses in Tables 20 and 21 suggest that a large part of the variances are accounted for in the scores associated with Therapist C. These scores indicate a definite preference for Therapist C when compared with those of Therapists A and B.

Perceived Characteristics of the Three Therapists

It was assumed that this definite indication of preference should also be reflected in observed and significant differences in the patients' impressions of the therapists. It was expected that the most significant differences would appear in comparisons of patient impressions of Therapist C with the impressions of Therapists A and B.

A means of comparison was afforded by the ratings of the therapists used for measuring the patients' perceptions of the therapists. This test provided 6 scores for each therapist for each need, indicating the patients' estimates of how characteristic a need was of a particular therapist. The scores ranged from 1 to 8. A score of 8 indicated the need was perceived to be highly characteristic of a therapist, and a score of one indicated the need was considerably less characteristic of a given therapist. (The reliability data for this scale were presented in Chapter II.) The mean score for each need for each therapist then, indicated the degree to which a particular need was seen as characteristic of a given therapist by all 42 patients. A graph showing these mean scores is presented in Figure 1. Visual analysis of this graph shows Therapists A and B to be quite

similar with few real differences. Whereas, the means for Therapist C are quite different from Therapists A and B, particularly on needs #4, #5, #9, #10, #11, #14 and #17. T-tests were computed on the difference between the means for the three therapists over the 21 needs. These t-tests are presented in Table 22. Of the 63 t-tests, 13 were statistically significant, six at the .01 level, and seven at the .05 level. Only one of the differences between Therapist A and Therapist B was significant ($P < .05$). There were eight significant t-tests between the means of Therapist C and Therapist A, five at the .01 level and three at the .05 level; and there were four significant differences between the means of Therapist C and Therapist B, one at the .01 level and three at the .05 level. The greatest differences in the patient's impressions of the therapists are in the differences between Therapist C and Therapists A and B. Therapist C was significantly higher than both Therapist A and B on needs #5, Autonomy; #11, Exhibition; #17, Rejection; and significantly lower than both on need #14, Nurturance. Therapist C was also significantly lower than Therapist A on need #6, Blame Avoidance; #12, Harm Avoidance; and #16, Play. Therapist C was significantly higher than Therapist A on need #10, Dominance; and #16, Play.

Table 22

T-tests between Therapists' Mean Scores on 21
PIT Needs as Characterized by Patients

Needs	A with B	A with C	B with C
# 1 Abasement	.1787	1.0036	.8573
# 2 Achievement	.0000	1.1493	1.2661
# 3 Affiliation	.6864	.0871	.5414
# 4 Aggression	.1463	1.8055	1.7441
# 5 Autonomy	.2704	2.3414*	2.5605*
# 6 Blame Avoidance	2.1458*	2.7681**	.6507
# 7 Counteraction	.5880	1.7679	1.2425
# 8 Defendance	1.7111	1.8236	.1967
# 9 Deference	.8068	1.7549	1.0478
#10 Dominance	.6209	2.3028*	1.5065
#11 Exhibition	.1613	2.8285**	2.5173*
#12 Harm Avoidance	1.9363	2.7360**	.7647
#13 Inferiority Avoidance	1.5116	1.7704	.4791
#14 Nurturance	.4580	3.3058**	2.9528**
#15 Order	.0000	.1714	.1494
#16 Play	1.9145	2.4694*	.7295
#17 Rejection	.3821	3.1566**	2.6235*
#18 Sentience	.7951	1.1410	.3642

Table 22, Continued

Needs	A with B	A with C	B with C
# 19 Sex	.2741	1.5251	1.6850
# 20 Succorance	.5799	1.5198	.693
# 21 Understanding	.6209	.9291	1.4444

*p < .05
**p < .01

CHAPTER IV

DISCUSSION

Fit of Patient and Therapist (as he is perceived by the patient)

The results of this study suggest that Hypothesis I is tenable. The data suggest that the patients had the most favorable expectation for therapy with the therapist whose perceived needs were most similar to their own highly valued needs. This is demonstrated empirically by the statistically significant lower discrepancy scores which were found for the most preferred therapist when compared with the scores of the least preferred therapist for both the actual rankings and the Semantic Differential Factor P (Power).

These findings might lend some support to the work of Heine and Carson (1962) whose results in comparing personality patterns of the patient and therapist on the MMPI suggested that the most effective patterns were not too similar, but not dissimilar. Vogel's (1959) results also suggested that similarity with respect to attitudes of patient-therapist pairs would enhance their degree of satisfaction with the relationship. Currier's results (1963) on the other hand suggested that patients with same sex therapists tended to rate the relationship good when their values were different from those of the therapist. However, she combined the data of same sex pairs, male with male, and female with female in the same analysis. There may be a different principle involved with female patient and female therapist, than with male patient and male therapist, just as there

appears to be different principles involved with opposite sex pairs.

Hypothesis II predicted that the patient's level of conflict about his most highly valued needs would have a significant bearing upon the characteristics of the therapist for whom he would have the most favorable expectation of outcome. The results of this study, however, did not support this formulation. Further analyses with the devalued needs were also insignificant. That is, therapists were not ranked significantly lower because they had needs which the patient devalued and had conflict about. On the basis of these results it would seem that there are no clear relationships of the degree of conflict in regard to different needs with therapist preference as measured in this study. There was a tendency regardless of group placement for the lowest discrepancies to be associated with the least preferred therapists and the highest discrepancies to be associated with the most preferred therapist. For the High Conflict Group, this means that the most preferred therapist expressed the needs that they were most conflicted about. For the Low Conflict Group it can only be stated that the most preferred therapist did not express the needs that they had little conflict about. Perhaps a number of principles operate, dependent upon factors not delineated at this time. Various individual needs or types of needs may be governed by different principles which operate in opposing ways. When combined in an analysis such as this, their specific directions could be cancelled out. For example, needs for Affection and Inclusion, as measured by Schutz (1958), may operate in such a way that a patient who highly values these, and is unsuccessful in satisfying them, might

seek a therapist who expressed affection and inclusion. The therapist in this case might serve as a teacher or an example for the patient to follow. Whereas, a patient who highly values needs for control, but is unseccessful in achieving satisfaction of them, may seek a person who is not seen as valuing control needs highly. This would be consistent with the general hypothesis proposed in this study.

The suggestion that several different principles may operate in the relationship between need structures in psychotherapy appears to present itself in the results of Hypothesis III. The consistently suggestive relationship which approaches or reaches significance through many of the analyses of the Control Needs as compared with the Inclusion and Affection Needs seems to support this.

The failure of the Affection or Inclusion needs to show any consistent trend suggests at least two explanations. It suggests, of course, that there may not be any relationships between a patient's wanted dimensions of Affection and Inclusion and this perception of the therapist's expression of these dimensions as measured in this study. It also again permits speculation that perhaps these needs are governed by other principles than Control type needs. For example, it seems possible that Affection and Inclusion needs do not demand the same type of interaction and compatibility as Control needs. A Control need interaction seems to imply a more specific situation where a patient either wants to control others, or wants to be controlled by others. Whereas, it seems possible that patient, and/or therapist may have both a high dimension for expressing love and inclusion toward

others, and a high desire to be loved and included by others without producing major conflict in a relationship, or within a particular patient.

The significant relationship for control needs when the need to be controlled is stronger than the need to exert control over others, instead of the reverse, suggests a more complex type of interaction than originally anticipated. It may be that a strong need to control others and a strong need to receive control from others within the same patient produces considerable anxiety and conflict. Specifically, a need to express control of one's therapist may give rise to conflict. This type of patient may be unable to seek a relationship with a therapist whom he felt might control him, because he also seeks to control others. However, when the patient clearly desires control from others, he will most likely seek a relationship with a therapist whom he anticipates will exert the most control over him and thus satisfy his needs. These results support the suggestions and findings of Leary (1957), Snyder (1961) and Schutz (1958) regarding the possibility of a patient-therapist "fit" based upon a reciprocity or compatibility of need structures.

The significant differences between the mean scores on the Semantic Differential Factors show this instrument's ability to reflect accurately the actual rankings of the patients on their expectations for favorable outcome in psychotherapy. These results suggest further that it can be effective in assessing the patients' feelings and expectations about a psychotherapeutic relationship. The present research confirms that of Currier (1963), and a number of other

studies on the applicability and value of this instrument.

Order of Presentation and Preference Relationship

Analyses of the order of presentation definitely indicate a relationship between the order of presentation and the order of preference for therapists. The patients were inclined to have a more favorable expectation for outcome with the therapist presented second or third than for the therapist presented first. This may be interpreted as support for a widely used practice of "intake" interviewing or team evaluation where the patient has several contacts with the professional staff prior to starting therapy. It might also be that the patient simply becomes more confortable with the situation and knows better what is expected of him.

Relationships between Perceived Characteristics of Therapists and Therapist Preference

One of the most interesting aspects of this study is found in the comparison of the perceived characteristics of the therapists as indicated by the Behavior Rating Scale and the preferences expressed for the therapists in the actual rankings. Therapist C was rated significantly higher than Therapist A and/or Therapist B on the needs for Autonomy, Dominance, Exhibition, Play and Rejection, and significantly lower than Therapist A and/or Therapist B on needs for Blame Avoidance, Harm Avoidance and Nurturance. Other needs which showed Therapist C rated higher, but not significantly different, were needs for Aggression, Counteraction, Defendance, Sentience, Sex and Understanding. Needs which showed Therapist C lower, but not significantly different, were Abasement, Achievement, Deference,

Inferiority Avoidance and Succorance. By referring to Table 1 in Chapter II, which shows the conversion of the PIT needs to the FIRO-B need categories, it is readily evident that with exception of #17, Rejection, the needs on which Therapist C was rated highest are the FIRO-B Control. The needs on which Therapist C was rated lowest were the Affection and Inclusion needs.

The highly significant preference for Therapist C (Table 20, page 52) seems to reflect the influence of this therapist's perceived personality. The patients in this study had the most favorable expectation for psychotherapeutic outcome with a therapist who was seen as independent and controlling; controlling in that he expressed achievement, aggressiveness, autonomy and dominance, but would not nurture the patient, attempt to solve his problems, or seek to avoid blame or difficulty.

In many ways these needs are those which characterize and reflect the problems and issues which are most important and pertinent to the stage of socialization experienced by most of the patients of this study. They are male adolescents, or young adults who are still dependent upon parental aid, but who are struggling to find their own independence and acceptance as individuals. They still need some control, but in a way which emphasizes and supports their ability to deal with their own problems, without the nurturing characteristic of many parent-child relationships. Therapist C's perceived personality appears to have "fit" more closely the needs and wants of a majority of the patients in this study. It might be said that Therapist C approximated more closely the concept of the "ideal" psychotherapist

for the major portion of the patient population used in this study. This could be compared with the findings of Parloff (1956) which suggested that the therapeutic relationship would have a more favorable prognosis when the therapist perceived the patient as more closely approximating his "ideal patient" concept.

It is possible that these results indicate a relationship specific to this population and the stage of development represented by most of the patients. It is also possible that the found relationship is accentuated by the fact that the patients were still in college, and that it would be less if they were more independent. These results do, however, appear to support the concept of a patient-therapist fit which would increase the expectation for successful outcome in therapy.

Future Research

As for future research, the ultimate question that might be asked still remains to be answered. That is, even if the patterns suggested by the results of this study and others are true, does the patient in fact have a more favorable and succesful outcome with the therapist of his choice? The extensive studies of J. McV. Hunt (1959) have suggested that getting the requested therapist was very important to some prospective patients, and that it might be associated with favorable outcome in therapy. However, it may be that an inverse relationship, the patient with the therapist of least favorable expectation, would be the most successful in actual therapeutic contact. Though the results of the present study might be suggestive, it is felt that further research with refinement of theory

and method is needed before predictions of outcome based upon patient choice of therapist can be made.

Generally, it does appear that different principles may govern a given need or need cluster. For example, the Control needs in Hypothesis III appeared to follow the original predictions and the Inclusion and Affection needs did not. Other principles were suggested that may influence these needs. Further research on these relationships would permit more accurate assessment of the need-impression interaction. A more specific delineation of the relationship regarding the similarity of values between the patient's most highly valued needs, and his impression of therapists' needs is needed. Is the relationship similar to that posed by Heine and Carson (1962)? Though no relationship was found between the degree of conflict and outcome expectation, the results suggested that some differences may be present. Are these differences predictable and meaningful? It seems reasonable to assume that the degree of conflict about one's most highly valued needs would affect such things as impressions of a helping person's personality and of eventual outcome. The present research techniques or instruments may not be sensitive enough to discover this relationship.

Perhaps the most interesting investigations would further explore the general area of this study in relation to the need compatibility dimensions as proposed by Schutz (1958). He suggested that the expressed dimension of one member of the dyad must equal the wanted dimension of the other member of the dyad for the most favorable compatibility. The results of this study have supported his

general hypothesis for control needs, but indicate that a slightly different manipulation of the interaction could be potentially more satisfying and successful, particularly when the patient desires control from others more than he desires to control others. If this type of planned matching could be combined with some of the suggestions of Apfelbaum (1958), which indicate an enduring set of first patient impressions in therapy, a potentially even more satisfying and successful relationship might be established.

CHAPTER V

SUMMARY

Research in psychotherapy has been difficult partially because of the number of pertinent variables and their interactive effects. One of the most promising lines of research has focused upon the relationship between the patient and therapist. A prevalent concept has stressed that the psychotherapeutic relationship may be significantly affected by the relative compatibility of the needs of the patient and therapist. The present study was an investigation of the relation between a "fit" or match of patient and therapist and the patient's characterizations of the expected relationship and outcome.

Forty-two subjects were secured at the Counseling Center and the Mental Health Clinic of the University of Florida. They had applied for help with personal problems, but had not begun treatment at the time of the study. After measures of the patients' need structures were secured, they each viewed three motion pictures each showing a different therapist in action with the same patient. Immediately after each film, they were asked to complete two forms, one of which indicated their impressions of the therapist's need structure and the other characterized the expected relationship with each therapist. After all three films were presented, the patients were asked to rank the therapists according to their most favorable, second favorable and least favorable expectations of outcome.

Patient and therapist needs as perceived by the patient were compared on three bases; similarity of values, the effect of the patient's degree of conflictedness about his highly valued needs, and the degree of reciprocity between patient and therapist needs. Each comparison was then related to the patient's indication of favorable expectation for outcome on two separate criteria. Three hypotheses were formulated.

Hypothesis I predicted that the patient would have a more favorable expectation of outcome with a therapist as his needs were perceived to be more similar to the highly valued needs of the patient. The results suggest that such a hypothesis is tenable. Statistically significant differences were found in the degree of differences between the values of the patient and the most preferred therapist when compared with the differences between the values of the patient and those attributed to the least preferred therapist. The patients had the most favorable expectation for the therapist whose perceived needs were most similar to their own highly valued needs.

Hypothesis II predicted that the patient's level of conflict about his most highly valued needs would differentially affect his expectation of outcome with a therapist.

1. The patient with high conflict about his highly valued needs would have a more favorable expectation of outcome with a therapist as he perceived the therapist's needs to be different from his own.

2. The patient with low conflict about his highly valued needs would have a more favorable expectation of outcome

with a therapist as he perceived the therapist's needs to be similar to his own.

There were no significant differences for either the High Conflict or Low Conflict Groups. The tables did suggest a trend for the highest differences to be associated with the most preferred therapist and the lowest differences to be associated with the least preferred therapist, regardless of group.

Hypothesis III predicted that a patient would have a more favorable expectation for outcome with a therapist as he perceives him as having needs reciprocal to his own. Specifically, it was predicted that a patient would have a more favorable expectation for outcome of therapy for a therapist as he was seen as needing to express what the patient needed to receive. A highly significant relationship was found when the patient's need to receive Control from others was greater than the need to express Control toward others. He had the most favorable expectation for outcome with a therapist who would most express control toward him and thus fulfill his needs.

A highly significant relationship was found between the order of presentation and the preference order or order of ranking. These results show that the patient is inclined to have a more favorable expectation for outcome with the therapist presented second or third than for the therapist presented first. This was interpreted as support for the widely used practice of "intake interviewing" or team evaluation where the patient had a number of contacts with professional helping people prior to starting therapy.

A distinct preference for one therapist (C) was interpreted to reflect the influence of that therapist's perceived personality, and that he may have "fit" the needs of the patients in this study. Further support for this was found in the significant differences between the patients' impressions of the therapists. Therapist C was found to be significantly different from Therapists A and B on Control needs. In general, patients in this study had the most favorable expectation for outcome with a therapist who was seen as independent and controlling, controlling in that he expressed achievement, aggressiveness, autonomy and dominance, but who would not nurture the patient or solve his problems for him. It was felt that this might be a characterization of the "ideal" therapist, and that they reflected the problems and issues which were most important and pertinent to the stage of socialization that most of the patients in the study were experiencing.

It appeared consistent with the results of this study to suggest that predictable relationships do exist between a patient's need structure, his impressions of therapist's needs, and his expectations for outcome in psychotherapy. Support was given for the concept of patient-therapist fit based on the compatibility of their need structures. However, further refinement of theory and method and study of the patterns of interaction in shared valued and in reciprocity of needs is needed. Only when therapist and patient are paired on a planned basis and the course and outcome of therapy determined will the eventual value of the present results be realized.

APPENDICES

APPENDIX A

Sequence of Procedures and Instructions to Subjects

Applicants for psychotherapy at the two centers who met the criteria set up were asked to participate in the study.

Instructions

The reason I wanted to talk with you is to ask if you would be willing to participate in a research project that I am doing as part of my graduate work. It is completely separate from the Counseling Center (or Infirmary) and is not part of any work being done there. Your participation is strictly voluntary and nonparticipation will not influence your experience here in any way.

I am attempting to study some aspects of the psychotherapy or counseling situation, specifically related to people who have asked for help, but as yet have not been seen by a counselor. Fortunately, you meet the requirements for my study.

Scheduling of your participation can be made at your convenience. The total time involvement would be less than two hours. All records will be confidential and individual results will not be made available to anyone. The final data will appear in group form without names.

Are there any questions you would like to ask?

Do you think you would be willing to participate?

If they agree to participate:

Have you ever been seen by a counselor or therapist before?

Do you personally know or have you had continued contact with any of the following people whose names I will read to you?

(The three therapists' names were read at this point.)

If subject was not rejected on basis of above:

Picture Identification Test and FIRO-B were administered.

1. PIT (Complete)
2. FIRO-B

Then the following instructions were given:

You have come to the University Counseling Center (or Mental Health Clinic) for help in dealing with some personal problems which you feel to some degree unable to handle yourself. The specific nature of your problem may be quite varied. It may be with parents, or other family members, a girlfriend, sweetheart, wife, your course work or educational goals, or just something about yourself that worries you. Since these problems are very important and personal to you, and at times perhaps uncomfortable to you, the personality of the therapist, or the "kind of guy" you talk to, will be important.

In this study, I am attempting to see how patients perceive and feel about therapy with different therapists.

You will now be shown moving pictures of three therapists in a simulated counseling situation with the same patient. The patient is playing the same personality with the same problem with each therapist. The therapist knew only that the patient was playing a role of a man of the same age who had a problem. The therapist was to be himself as he is in a regular counseling situation. I would like for you to try to put yourself in the place of the patient as if you were being seen by this person. How would you feel and how would his personality seem to you?

After each film you will be asked to complete some forms on your impressions of the therapist you have just seen.

Film 1 was shown

1. Behavior Rating Scale (BRS)
2. Semantic Differential

Film 2 was shown

1. Behavior Rating Scale (BRS)
2. Semantic Differential

Film 3 was shown

1. Behavior Rating Scale (BRS)
2. Semantic Differential

Their Therapist Rankings and Comparisons were taken and subjects were dismissed.

APPENDIX B

PIT Need Scores

Attitude Stanines

Patients	Needs 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	3	2	5	6	3	5	5	8	4	1	4	5	6	8	2	5	3	5	1	8	6
2	8	3	4	6	1	7	1	3	3	2	6	5	8	4	4	5	4	5	3	8	5
3	3	4	5	4	3	2	8	6	6	4	3	4	5	5	3	3	8	1	5	8	6
4	7	1	4	6	7	4	7	6	3	5	5	1	4	4	2	5	5	4	4	2	7
5	4	6	4	4	1	8	5	5	5	3	2	7	8	5	2	3	3	8	1	4	6
6	1	7	5	6	7	6	3	5	8	5	8	5	2	2	1	5	4	6	4	4	3
7	5	5	3	7	1	8	4	3	5	3	4	8	8	4	1	8	3	4	1	7	3
8	2	5	5	3	6	5	4	6	6	4	5	3	1	2	5	8	7	4	7	4	2
9	3	4	8	3	5	6	1	6	1	4	5	5	4	4	1	7	4	6	7	4	6
10	3	6	4	2	5	6	7	5	2	5	1	5	4	4	7	4	2	7	3	5	8
11	2	4	5	5	5	5	3	6	5	4	4	4	1	8	6	5	1	3	5	7	8
12	4	4	2	1	4	7	4	8	4	4	1	6	6	5	8	3	4	7	1	4	6
13	5	4	3	8	7	1	6	1	7	5	2	4	5	1	7	1	7	6	5	5	3
14	5	5	1	8	6	3	4	5	5	7	7	4	5	4	3	6	3	1	7	3	2
15	5	4	1	4	4	7	3	3	2	8	6	6	2	5	6	1	3	8	5	5	6
16	6	6	4	4	4	6	6	4	2	1	3	4	6	6	5	4	4	6	3	4	8
17	4	6	5	5	5	4	6	4	3	5	3	3	3	6	4	5	5	7	3	2	6
18	2	1	1	8	6	1	3	5	8	8	4	8	5	3	1	4	8	3	6	7	2
19	6	5	2	4	1	7	3	8	2	5	4	7	5	3	8	1	3	6	2	7	6
20	3	2	2	6	1	3	8	3	2	5	5	5	6	6	2	5	6	7	4	8	6

Appendix B, Continued

Patients	Needs 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
21	4	6	7	4	3	5	5	4	5	6	5	1	4	6	4	8	6	1	3	4	4
22	2	6	3	7	6	4	8	5	4	3	2	3	1	6	5	4	4	6	7	5	2
23	3	3	5	3	5	3	4	6	3	6	3	6	7	4	6	5	2	1	8	4	8
24	7	5	1	6	5	5	5	2	6	1	2	5	7	5	4	1	8	7	3	4	6
25	4	2	7	7	5	5	1	1	6	2	6	8	2	5	6	8	4	6	2	4	3
26	4	5	1	3	2	5	4	8	4	4	3	1	4	4	7	6	5	7	4	7	4
27	3	4	6	2	4	3	5	6	2	5	7	4	3	6	8	4	2	4	4	6	4
28	4	3	5	4	1	7	7	5	4	4	3	2	6	6	3	5	8	5	2	6	6
29	4	6	3	3	1	6	6	2	4	5	2	6	5	2	7	4	5	7	4	3	8
30	2	6	3	4	8	4	3	5	6	7	4	4	2	1	5	1	6	7	5	5	8
31	3	1	5	4	5	1	6	6	4	3	5	5	8	3	4	5	5	3	8	6	3
32	3	5	8	2	5	4	1	5	4	1	5	5	7	6	3	7	4	4	6	8	3
33	5	4	5	5	5	5	8	5	4	5	3	2	3	2	7	5	5	6	4	1	6
34	4	3	1	8	2	7	2	3	6	4	5	7	8	5	2	6	2	8	6	2	4
35	5	7	6	8	4	5	4	4	6	2	3	5	4	5	5	8	6	2	3	4	1
36	4	8	6	7	8	4	4	5	3	4	3	1	4	4	6	7	3	2	4	6	3
37	4	4	3	5	8	1	5	1	6	5	5	3	4	3	7	1	6	7	3	3	8
38	4	6	1	6	3	6	3	5	5	1	1	8	7	6	3	3	3	8	2	6	6
39	6	4	4	2	1	3	2	5	4	7	7	5	5	8	3	4	6	4	6	2	5
40	4	4	5	6	7	4	2	2	4	7	6	5	2	3	4	6	1	3	7	8	3
41	5	4	3	7	6	6	1	4	4	1	7	6	6	3	7	8	2	3	3	8	6
42	3	5	1	4	8	3	2	7	4	5	7	4	7	3	3	5	7	6	4	1	4

APPENDIX C

PIT Need Scores

Association Index Stanines

Patients	Needs 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	4	6	3	4	3	4	8	1	5	5	2	2	4	8	8	6	3	6	3	6	8
2	6	3	1	3	3	2	4	1	3	4	3	3	4	4	4	2	4	5	3	4	3
3	4	6	3	5	6	5	6	5	7	7	7	6	6	4	3	2	7	1	4	1	1
4	1	1	3	5	3	4	4	3	5	6	4	2	2	4	3	2	7	3	2	5	2
5	4	7	4	6	7	3	5	2	3	6	5	5	6	5	4	4	3	7	4	5	4
6	4	1	4	6	6	6	3	5	5	6	4	4	2	7	5	3	4	6	4	1	4
7	7	3	6	6	8	8	4	6	7	8	7	8	7	7	4	1	4	4	7	7	4
8	3	6	3	2	5	7	4	4	5	6	4	2	4	7	2	6	3	5	4	1	6
9	4	4	2	7	6	5	4	2	4	7	6	4	3	4	4	1	6	3	4	2	6
10	6	5	6	5	1	3	5	2	4	3	2	5	2	1	8	5	5	5	5	5	5
11	2	1	6	7	4	3	2	2	7	5	5	5	4	2	4	4	6	6	5	1	3
12	5	3	3	3	4	7	4	4	3	4	5	4	1	8	4	4	4	8	6	4	3
13	7	2	6	5	4	5	2	6	4	4	6	5	7	3	4	5	6	2	4	8	1
14	4	1	4	5	2	8	1	4	5	2	8	8	7	5	5	8	6	6	8	4	4
15	3	3	5	4	1	5	4	4	3	3	2	3	1	6	4	5	6	4	1	6	1
16	5	6	4	5	4	5	5	4	5	5	7	5	5	5	5	7	6	4	6	6	5
17	5	5	3	5	8	6	7	2	7	7	6	7	5	7	6	1	3	6	7	6	8
18	5	8	4	8	7	5	1	5	8	8	1	1	6	5	5	5	8	8	7	6	5
19	6	4	4	8	6	4	1	5	7	6	3	4	3	4	6	1	8	3	4	5	4
20	7	3	3	4	5	6	6	7	5	3	5	1	6	5	6	3	4	6	2	6	7

Appendix C, Continued

Patients	Needs 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
21	5	4	4	5	5	3	2	4	6	2	3	4	4	2	4	4	5	2	4	6	5
22	5	4	6	6	4	4	2	4	6	5	5	5	2	5	4	5	6	6	2	1	3
23	1	1	5	4	1	4	5	4	5	3	5	3	1	4	5	4	7	3	3	5	2
24	5	3	6	7	7	4	4	6	3	7	8	4	4	8	5	5	6	7	8	4	6
25	4	3	4	1	2	2	3	4	2	1	5	3	3	5	4	5	4	5	2	4	3
26	7	7	8	7	7	7	8	6	7	6	8	3	4	8	5	4	4	7	8	3	6
27	6	4	4	5	4	4	6	4	5	4	8	4	5	8	7	7	4	6	5	5	6
28	4	5	4	7	8	7	4	8	7	7	4	1	7	8	5	5	3	7	4	7	5
29	4	5	2	5	7	6	5	7	7	6	5	5	7	5	7	4	6	8	6	6	5
30	6	3	4	2	4	6	1	1	4	4	3	4	3	5	5	6	7	5	4	5	2
31	2	1	4	1	2	5	1	5	1	2	3	3	5	5	3	4	4	2	2	5	1
32	6	4	5	7	4	6	4	6	7	5	4	6	4	4	2	5	5	7	2	5	5
33	4	3	3	7	6	6	2	8	4	6	2	8	8	5	4	2	6	6	4	7	5
34	5	2	4	4	3	3	5	4	4	3	2	4	5	5	3	4	4	5	2	5	4
35	5	7	4	5	3	6	5	7	7	6	3	7	7	4	8	4	6	6	6	7	4
36	6	5	5	5	4	8	6	7	3	4	5	5	2	5	5	4	2	4	3	5	4
37	4	2	4	6	6	6	4	6	5	6	4	5	4	5	4	1	6	3	4	1	1
38	5	8	8	5	6	3	5	3	6	6	8	3	5	6	3	6	8	6	2	2	6
39	4	8	4	7	7	7	5	4	5	6	6	8	6	4	4	5	2	6	8	6	6
40	4	3	8	2	2	2	4	2	2	3	8	3	4	3	6	8	3	2	5	5	3
41	6	4	3	1	3	5	3	3	4	4	2	4	5	3	5	4	6	3	1	4	3
42	5	5	5	3	1	3	4	1	2	3	4	4	2	5	6	5	4	4	3	1	5

APPENDIX D

Patients' FIRO-B Scaled Scores

Patients	Expressed Inclusion Behavior	Wanted Inclusion Behavior	Expressed Affection Behavior	Wanted Affection Behavior	Expressed Control Behavior	Wanted Control Behavior
1	3	0	1	3	5	5
2	3	7	6	2	4	8
3	7	8	5	6	3	4
4	3	0	0	2	8	3
5	6	8	6	3	7	9
6	7	9	6	5	9	9
7	3	8	5	4	2	2
8	8	5	3	3	8	8
9	7	7	7	4	5	9
10	7	2	5	1	5	5
11	5	6	3	5	4	3
12	5	7	3	3	5	6
13	4	0	1	1	4	6
14	2	0	0	0	1	3
15	4	6	3	3	3	3
16	6	6	6	8	5	4
17	8	6	4	5	5	3
18	7	9	6	9	4	5
19	7	6	3	3	4	6
20	5	4	1	3	5	2

Appendix D, Continued

Patients	Expressed Inclusion Behavior	Wanted Inclusion Behavior	Expressed Affection Behavior	Wanted Affection Behavior	Expressed Control Behavior	Wanted Control Behavior
21	4	0	2	2	5	5
22	3	1	1	3	9	4
23	4	1	2	1	2	3
24	0	0	0	0	1	4
25	9	8	2	2	4	8
26	6	9	4	5	6	4
27	5	3	6	5	9	7
28	0	5	0	2	0	8
29	5	0	9	7	5	9
30	1	0	1	1	7	3
31	4	8	5	4	4	9
32	3	1	2	5	2	2
33	2	1	5	5	1	9
34	1	0	4	2	5	6
35	6	1	2	5	3	5
36	2	0	0	3	2	4
37	5	8	4	6	7	4
38	2	4	5	8	6	5
39	0	7	0	2	6	5
40	2	0	3	0	8	8
41	6	8	3	5	3	4
42	4	8	2	6	7	6

APPENDIX E

PIT - Behavior Rating Scale

Name______________________________

Student #________________________

Instructions

On the next page you will find brief personality descriptions. Read each of the descriptions listed and then rate, using the rating scale below, how strongly you feel the given statement is characteristic of the therapist in the motion picture you have just seen.

Rating Scale

8. Highly characteristic	4. Somewhat uncharacteristic
7. Quite characteristic	3. Fairly uncharacteristic
6. Fairly characteristic	2. Quite uncharacteristic
5. Somewhat characteristic	1. Highly uncharacteristic

Place the number of the rating in the space provided before the description. For example, if you feel a personality statement is highly characteristic of the therapist just seen, you would place the number 8 in the space provided.

_8_ 1. Others think more highly of this man than he thinks of himself.

OR, if you felt that the statement was quite characteristic of him, you would place the number 7 in the space provided, and so on.

_7_ 1. Others think more highly of this man than he thinks of himself.

It is best not to spend too long in making your judgments. It is your first impression that is important.

Therapist___________________

8. Highly characteristic
7. Quite characteristic
6. Fairly characteristic
5. Somewhat characteristic
4. Somewhat uncharacteristic
3. Fairly uncharacteristic
2. Quite uncharacteristic
1. Highly uncharacteristic

____ 1. A man who readily admits his faults.

____ 2. A man who tries with all his might when he had a hard job to do.

____ 3. A man who feels having friends is more important than anything else.

____ 4. A man who shows it when he gets mad or angry.

____ 5. A man who does what he feels like doing without worrying about what others think.

____ 6. This man wouldn't do anything that others might think wrong.

____ 7. If this man fails at something, he tries harder than ever to succeed.

____ 8. A man who likes to have someone he looks up to for guidance and inspiration.

____ 9. When he is criticized, this man is quick to argue back and defend himself.

____10. A man who likes to have others follow his orders.

____11. A man who likes to make people sit up and take notice.

____12. A man who is especially careful to avoid danger.

____13. A man who often stays out of things because he feels he doesn't have the ability.

____14. Friends think this man is too sympathetic toward those who need help.

____15. A man who likes to keep things neat and orderly.

____16. A man who is always ready to relax and have a good time.

____17. A man who can turn people down when they don't do what he thinks they should.

____18. A man who enjoys the beauties of nature.

____19. A man who spends a great deal of time thinking about women.

____20. A man who likes to be around someone who is sympathetic and helpful.

____21. A man who likes to study and learn about things.

Therapist_______________

8. Highly characteristic
7. Quite characteristic
6. Fairly characteristic
5. Somewhat characteristic
4. Somewhat uncharacteristic
3. Fairly uncharacteristic
2. Quite uncharacteristic
1. Highly uncharacteristic

____ 1. A man who is very modest about his abilities.

____ 2. A hard working man.

____ 3. A man who likes to be around his friends as much as possible.

____ 4. A man who has a quick temper.

____ 5. A man who doesn't like to be bound by a lot of rules and regulations.

____ 6. Before he does anything this man tries to figure out whether people will think it is all right or not.

____ 7. A man who won't give up, even when things look hopeless.

____ 8. A man who tries to be like those he looks up to.

____ 9. This man snaps back if anyone criticizes him.

____ 10. A man who likes to have authority and give orders.

____ 11. A man who enjoys performing before a crowd.

____ 12. A man who likes to be sure it's not dangerous when he does something.

____ 13. A man who sometimes feels he isn't as good as others.

____ 14. A man who is apt to spoil children and pets by being very tenderhearted.

____ 15. A man who likes to have a place for everything and to keep everything in its place.

____ 16. A man who likes to have fun.

____ 17. This man won't waste his time and energy on people who don't deserve it.

____ 18. A man who likes art and music and poetry.

____19. A man who notices every good looking woman who goes by.

____20. A man who likes to have someone help him out when he is in a strange place.

____21. A man who likes to ask questions and gain knowledge.

APPENDIX F-1

Behavior Rating Scale (BRS) Scores
PIT Need Scores Attributed to Therapist A

Patients	PIT Needs 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	7	6	4	2	2	7	8	5	1	4	4	6	3	7	5	2	3	5	5	4	7
2	4	5	4	4	4	5	5	5	4	6	5	6	4	4	4	4	5	5	4	5	6
3	7	7	6	2	6	2	6	5	2	4	6	4	3	6	6	4	4	6	3	6	6
4	5	4	6	7	4	6	3	2	8	4	4	6	2	8	5	5	7	4	3	8	8
5	5	5	5	3	6	5	5	6	5	5	4	6	3	4	5	5	6	4	4	5	6
6	4	4	4	3	5	4	4	4	4	5	4	5	5	5	5	5	4	4	4	4	5
7	6	6	2	4	1	5	5	4	3	5	4	5	7	3	7	5	3	5	4	5	7
8	6	6	5	4	4	6	5	6	5	4	4	6	6	5	6	5	6	6	4	4	7
9	7	6	5	2	2	6	5	5	2	3	3	5	4	6	5	4	3	5	3	5	6
10	7	7	5	2	6	6	7	6	3	6	2	5	3	5	6	5	5	5	5	4	7
11	6	7	5	4	3	3	6	4	5	4	3	3	3	7	4	3	3	7	6	4	7
12	6	5	4	2	6	4	3	4	6	4	5	6	6	3	3	5	6	4	4	4	5
13	6	4	5	2	2	7	5	7	4	5	5	6	7	6	6	4	4	4	3	6	6
14	5	5	4	3	3	6	5	5	4	4	3	5	4	5	5	5	4	4	4	5	5
15	4	6	5	5	4	6	5	6	5	5	4	5	6	4	5	5	6	4	5	6	4
16	5	3	4	3	5	7	5	7	5	4	4	6	4	2	6	4	4	3	2	3	7
17	5	7	6	4	5	7	7	4	2	2	2	3	4	5	6	6	4	6	4	5	8
18	6	4	4	4	3	7	3	4	2	3	3	6	4	5	6	4	3	4	3	4	5
19	7	8	4	3	8	5	8	6	4	5	2	2	7	3	6	2	4	4	4	6	8
20	6	7	4	3	4	5	7	3	3	4	4	4	3	5	5	4	4	6	2	5	6

Appendix F-1, Continued

Patients	PIT Needs 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
21	7	6	3	4	4	3	5	3	3	5	3	3	4	4	5	4	4	5	4	3	6
22	5	5	1	1	4	6	6	3	2	3	2	5	3	7	7	4	4	6	3	4	6
23	6	7	5	4	4	5	6	5	4	4	4	5	3	4	6	5	3	5	4	4	5
24	7	5	3	8	4	7	6	3	7	6	4	7	2	5	4	1	3	6	6	7	4
25	3	2	3	2	4	7	2	2	2	3	3	6	4	3	5	4	5	5	4	3	5
26	5	8	4	8	6	3	8	7	1	4	1	5	2	2	8	5	5	7	1	3	8
27	6	6	5	4	4	5	5	5	4	4	4	5	4	5	4	5	5	5	4	5	5
28	4	4	4	6	5	5	5	4	6	6	5	5	4	4	5	3	6	2	3	3	5
29	5	6	3	3	3	5	5	3	4	5	5	4	3	5	5	5	5	5	4	3	6
30	4	6	4	4	7	2	6	6	4	6	6	3	2	2	5	4	5	6	5	4	7
31	6	5	4	4	3	3	4	3	4	3	4	5	4	4	4	3	2	6	4	3	5
32	7	7	3	2	5	6	5	2	4	4	1	5	4	6	5	4	1	3	2	5	7
33	8	8	6	2	1	8	7	5	4	4	3	6	2	7	7	5	3	7	3	6	8
34	6	6	3	2	5	4	6	4	3	3	3	5	3	5	4	6	4	5	4	4	6
35	5	5	5	2	2	3	5	5	3	3	2	5	3	3	5	3	4	5	3	2	6
36	6	6	4	4	4	6	7	5	6	4	4	5	3	4	4	4	6	4	3	4	7
37	7	6	7	3	2	5	5	7	4	4	5	2	4	7	4	7	2	6	4	7	5
38	5	5	4	3	4	5	5	5	3	4	4	5	4	5	5	5	4	5	3	5	5
39	5	4	4	3	4	5	4	5	4	4	3	6	6	4	3	3	5	4	3	5	5
40	5	7	6	4	4	6	7	8	6	2	6	3	7	3	5	4	5	3	2	4	5
41	3	6	5	2	1	5	5	6	2	4	4	5	7	5	4	2	1	1	1	6	5
42	7	7	4	4	4	4	6	6	4	3	3	5	5	5	6	4	4	5	4	6	6

APPENDIX F-2

Behavior Rating Scale (BRS) Scores
PIT Need Scores Attributed to Therapist B

Patients	PIT Needs																				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	7	6	6	2	6	5	5	2	4	1	2	2	3	6	5	5	4	7	6	6	7
2	6	5	5	4	5	4	5	4	5	6	3	6	4	4	3	5	4	5	3	3	6
3	7	7	4	4	5	2	6	5	4	4	4	4	3	6	6	6	6	5	2	5	6
4	4	5	4	4	5	4	5	6	4	3	3	2	2	5	7	6	6	5	3	4	5
5	4	4	5	5	3	5	6	5	6	6	6	5	4	4	3	6	6	5	4	5	5
6	6	6	4	4	3	3	5	2	2	5	1	4	3	2	6	5	5	6	4	3	7
7	5	6	3	4	2	2	5	4	4	2	2	3	2	5	6	5	2	7	2	6	8
8	6	7	5	5	2	2	7	7	6	6	3	6	5	7	5	4	7	3	2	3	6
9	5	5	4	5	5	4	5	4	4	4	4	5	4	4	5	5	4	5	4	4	6
10	5	7	5	2	4	5	7	7	5	6	5	4	4	5	7	6	5	5	4	4	7
11	7	7	4	4	6	4	7	3	3	3	2	4	3	5	7	6	6	6	5	3	8
12	5	4	5	3	2	5	4	6	3	2	2	4	5	3	5	3	3	7	3	7	5
13	6	7	5	7	7	4	7	4	7	7	6	3	3	2	6	6	7	6	6	4	6
14	5	4	6	4	3	5	5	4	4	5	4	6	5	5	3	4	5	5	3	5	6
15	5	5	5	5	4	6	4	6	5	5	4	5	6	4	6	5	5	4	5	6	4
16	5	6	5	3	4	6	5	4	4	4	4	6	3	8	6	5	4	6	2	4	6
17	6	8	5	2	2	2	8	5	3	2	2	3	1	5	8	6	2	6	3	5	8
18	7	5	5	2	2	7	4	5	4	5	5	5	5	7	7	6	4	7	3	5	7
19	6	8	5	2	1	6	8	6	2	5	5	5	7	3	8	4	5	4	2	7	7
20	7	6	5	2	2	3	7	2	2	3	2	3	2	5	6	4	3	5	3	4	5

Appendix F-2, Continued

PIT Needs

Patients	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
21	6	5	5	4	5	4	5	4	4	5	5	4	4	4	4	4	4	5	4	5	5
22	3	5	3	2	4	5	5	5	3	4	4	4	3	5	5	4	4	5	3	5	5
23	5	6	5	4	3	3	6	6	4	4	5	5	3	4	6	5	4	5	4	5	6
24	7	3	4	1	8	1	3	1	8	7	7	2	2	1	2	2	7	3	2	1	1
25	5	6	6	3	7	3	6	3	4	4	4	5	4	4	5	5	4	5	4	4	5
26	7	6	1	1	2	7	7	7	1	3	1	6	2	2	6	5	4	5	1	5	6
27	4	5	4	4	4	4	5	4	4	5	5	5	4	4	5	5	5	5	5	4	5
28	5	6	4	3	2	5	6	4	3	5	4	4	3	4	5	5	4	5	2	3	6
29	3	7	4	3	4	5	6	4	3	2	3	2	2	6	6	6	5	6	4	4	6
30	5	5	3	3	5	4	4	3	3	6	4	3	4	4	3	2	2	6	4	3	5
31	7	6	6	5	5	6	7	5	5	4	3	4	3	4	6	5	4	5	6	5	7
32	7	4	4	1	4	7	5	3	2	5	1	8	4	5	4	3	1	5	3	5	4
33	7	7	6	5	3	6	8	3	5	5	3	4	3	6	6	6	4	5	5	5	7
34	5	5	5	4	4	5	5	5	4	4	4	4	4	4	5	4	6	4	5	5	5
35	2	5	4	3	4	6	5	1	5	4	2	5	2	5	2	2	2	5	2	1	7
36	7	5	5	3	2	7	5	4	5	5	4	7	6	5	5	5	4	3	3	5	4
37	6	7	4	4	4	4	7	3	5	5	6	3	3	5	6	6	3	4	5	5	8
38	5	6	4	2	5	5	5	4	5	5	4	4	3	4	4	4	4	4	2	4	7
39	5	6	6	7	5	4	6	2	5	4	5	3	3	5	5	6	6	5	5	3	5
40	6	6	4	4	4	4	5	7	5	4	5	6	7	5	4	4	4	4	4	7	6
41	7	6	2	3	1	5	4	3	2	2	3	6	5	6	5	2	1	1	2	6	6
42	6	4	4	5	5	4	4	4	6	5	5	3	3	4	3	4	6	4	4	4	5

APPENDIX F-3

Behavior Rating Scale (BRS) Scores
PIT Need Scores Attributed to Therapist C

	PIT Needs																				
Patients	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1	4	6	5	3	6	4	6	3	3	2	5	3	3	6	4	6	4	6	7	3	7
2	7	7	7	3	3	4	5	3	4	6	7	2	3	6	7	6	5	6	5	5	6
3	7	6	4	2	6	3	7	5	4	6	6	4	2	3	7	5	7	6	3	5	6
4	7	7	3	3	6	4	8	5	4	3	3	2	1	5	4	6	4	6	3	6	8
5	5	4	5	4	3	6	6	4	7	5	6	5	3	4	6	5	6	6	4	5	7
6	7	7	4	4	4	4	6	3	3	5	3	4	2	2	5	6	5	5	4	3	6
7	7	7	3	5	2	4	5	3	3	6	2	3	4	3	6	6	3	5	3	5	7
8	7	7	6	4	4	6	6	6	4	5	7	6	6	6	7	7	6	5	4	5	7
9	7	5	5	3	4	5	6	3	2	5	4	6	4	5	4	6	4	4	4	7	5
10	3	6	6	3	4	5	6	6	5	7	6	4	3	5	6	7	5	5	5	4	7
11	7	7	5	5	4	3	8	2	2	3	2	3	2	4	6	3	5	6	5	5	7
12	7	6	5	4	4	5	6	6	4	5	4	2	2	3	7	4	4	5	3	5	7
13	7	8	5	8	8	2	8	3	7	8	8	4	3	2	5	7	7	6	6	3	6
14	4	5	4	3	4	5	5	5	6	5	6	5	3	4	2	5	5	5	5	5	5
15	3	6	6	5	3	6	4	2	5	4	4	7	7	4	5	4	5	3	5	7	3
16	4	6	5	3	6	5	7	7	5	6	6	5	2	3	6	5	5	3	3	4	6
17	1	7	5	8	8	2	7	8	6	7	8	2	1	1	8	5	8	5	2	1	8
18	6	6	6	7	6	4	5	4	7	6	8	2	2	4	5	6	5	6	6	6	8
19	4	6	4	2	2	7	4	4	2	5	4	7	8	5	7	4	4	4	2	3	6
20	6	7	4	4	5	4	6	4	3	3	6	3	3	3	3	4	6	6	3	4	6

Appendix F-3, Continued

PIT Needs

Patients	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
21	4	5	4	2	3	5	4	5	6	5	3	6	4	4	4	4	5	5	3	5	7
22	2	7	2	6	7	2	7	2	7	6	6	2	2	3	6	2	6	4	5	4	6
23	2	4	3	2	5	5	3	3	6	6	6	5	5	4	5	5	6	5	5	5	5
24	7	5	5	7	8	1	6	5	3	1	4	1	4	1	7	8	8	5	5	1	4
25	6	7	6	3	6	6	6	3	5	5	5	5	3	4	5	5	5	5	4	4	5
26	8	8	1	8	8	2	8	5	1	4	1	3	1	1	7	2	7	8	1	5	8
27	5	4	4	3	5	5	5	6	4	5	5	5	4	4	4	5	5	5	5	5	5
28	6	6	4	4	4	5	6	4	2	5	4	4	2	2	5	5	5	5	4	3	5
29	8	6	5	4	4	3	7	4	3	2	2	3	2	5	5	7	5	5	4	3	7
30	5	5	4	2	6	3	5	2	5	4	5	4	3	3	5	4	4	6	4	3	7
31	5	6	5	5	4	5	5	5	5	2	2	4	3	3	6	6	5	5	6	5	5
32	5	6	4	3	4	5	7	2	4	4	2	5	5	2	5	6	1	6	3	6	8
33	3	7	2	1	6	4	8	1	8	6	3	6	1	1	5	2	7	3	2	2	8
34	3	5	4	5	5	4	5	3	5	5	5	4	3	4	3	4	6	4	5	3	5
35	1	6	2	2	6	4	5	2	5	4	2	5	5	4	4	3	3	6	2	1	6
36	8	8	7	5	4	4	7	6	6	5	5	4	2	4	5	6	6	5	3	3	7
37	4	5	3	6	7	2	5	3	7	6	6	3	2	4	5	5	5	3	4	3	5
38	3	5	5	6	5	4	5	4	5	6	4	5	6	2	3	5	3	6	4	2	5
39	7	5	5	2	1	5	6	2	3	3	5	4	5	6	4	4	4	7	5	3	7
40	7	5	4	4	4	7	5	8	3	6	4	5	7	7	2	2	4	4	4	7	5
41	5	4	3	6	2	8	5	5	3	5	6	5	7	2	3	4	4	2	2	6	5
42	7	7	3	4	7	2	7	7	5	4	4	5	4	4	6	5	7	7	5	7	8

APPENDIX G

Semantic Differential

Instructions:

One of the purposes of this study is to measure the patient's expectations of his relationships with several therapists. This form is intended to enable you to express the feelings you would expect to have after a series of interviews with a given therapist. Rate each relationship on each of the scales presented on the following page.

How to use these scales:

If you feel that your relationship with the therapist just seen would be very closely related to one end of the scale, you should place your checkmark as follows:

Large _X_:____:____:____:____:____:____: Small

If you feel that this relationship would be very closely related to the "large" end of the scale you should place your check mark as shown above.

If you feel that the expected relationship is quite closely related to one or the other end of the scale (but not very closely so), you should place the check mark as follows:

Large ____:_X_:____:____:____:____:____: Small

OR

Large ____:____:____:____:____:_X_:____: Small

If you feel that the expected relationship being rated seems only slightly related to one side as compared with the other (but that it's not really neutral) then you should check as follows:

Large ____:____:_X_:____:____:____:____: Small

OR

Large ____:____:____:____:_X_:____:____: Small

If you think whatever is being judged (in this example the therapist) is neutral on the scale, both sides of the scale equally associated with him, or if the scale is completely irrelevant or unrelated to the word, then place your mark directly in the middle:

Large ____:____:____:_X_:____:____:____: Small
Neutral

Be sure to: (1) Place your check mark in the middle of the spaces
(2) Check every scale for every therapist
(3) Use only one check mark on a single scale
(4) Work quickly; it's your first impression that's important

Expected Relationship with

Therapist ______

Good ____:____:____:____:____:____:____:Bad

Weak ____:____:____:____:____:____:____:Strong

Smooth ____:____:____:____:____:____:____:Rough

Cold ____:____:____:____:____:____:____:Hot

Trusting ____:____:____:____:____:____:____:Suspicious

Violent ____:____:____:____:____:____:____:Gentle

Colorful ____:____:____:____:____:____:____:Colorless

Diffuse ____:____:____:____:____:____:____:Concentrated

Valuable ____:____:____:____:____:____:____:Worthless

Passive ____:____:____:____:____:____:____:Active

Sharp ____:____:____:____:____:____:____:Dull

Subtle ____:____:____:____:____:____:____:Obvious

Emotional ____:____:____:____:____:____:____:Rational

Sad ____:____:____:____:____:____:____:Happy

Safe ____:____:____:____:____:____:____:Dangerous

Insincere ____:____:____:____:____:____:____:Sincere

Complex ____:____:____:____:____:____:____:Simple

Hazy ____:____:____:____:____:____:____:Clear

Varied ____:____:____:____:____:____:____:Repetitive

Meaningful ____:____:____:____:____:____:____:Meaningless

Tense ____:____:____:____:____:____:____:Relaxed

Pleasant ____:____:____:____:____:____:____:Unpleasant

APPENDIX H

Therapist Comparisons and Rankings

You have now completed your viewing of the three therapists. I would now like for you to indicate your expectations for therapy outcome if you were able to be seen by these therapists. That is, based on your impressions from the films, what would you expect the outcomes to be.

First, I would like you to rank the therapists, listing first the therapist with whom you would have the most favorable expectation for outcome; second, the therapist with the next most favorable expectation; and third, the therapist with whom you would have the least favorable expectation of outcome. For example, if you expect the most favorable outcome for you would be with therapist B, and the next favorable outcome with therapist C, and the least favorable outcome with therapist A, then you would put in your rankings:

1. B 2. C 3. A

Therapist Rankings

1.
2.
3.

Next, I would like you to think about the various differences that you may see between the therapists and compare them on this dimension. Using the scale below, indicate the differences you see between them in the following ways:

Difference Comparisons Scale

1. Little or no difference
2. Somewhat different
3. Quite different
4. Highly different

If you feel that A & B are highly different, you would place a 4 beside that comparison, but that there was little or no difference between B & C, you would place a 1 beside that pair, and that therefore, there was a high difference between A & C, thus a 4 rating beside that pair.

		Thus, you would be saying that A is highly different from both B and C, and that B and C are so similar that there is little or no difference in your impression of them, etc.
A & B	4	
B & C	1	
A & C	4	

Your Difference Comparisons

A & B ____ B & C ____ A & C ____

APPENDIX I

Preferences for Therapists for the Actual Rankings and Semantic Differential Factors E and P

Patients	Actual Rankings			Semantic Differential Factor E			Semantic Differential Factor P		
	Most Pref.	2nd Pref.	Least Pref.	Most Pref.	2nd Pref.	Least Pref.	Most Pref.	2nd Pref.	Least Pref.
1	B	A	C	B	A	C	A	B	C
2	C	B	A	C	A	B	C	A	B
3	C	B	A	B	C	A	C	A	B
4	C	B	A	C	B	A	C	B	A
5	C	A	B	C	A	B	C	A	B
6	C	B	A	C	B	A	C	B	A
7	C	B	A	C	B	A	C	B	A
8	C	B	A	A	C	B	C	B	A
9	C	B	A	A	C	B	C	B	A
10	C	B	A	B	A	C	B	C	A
11	C	A	B	C	B	A	B	C	A
12	C	B	A	C	B	A	C	A	B
13	C	B	A	C	B	A	C	B	A
14	A	C	B	A	C	B	A	C	B
15	C	B	A	C	B	A	C	B	A
16	C	B	A	C	B	A	C	B	A
17	B	A	C	B	A	C	B	A	C
18	C	A	B	C	A	B	C	A	B
19	B	C	A	B	A	C	B	C	A
20	A	C	B	C	A	B	A	C	B

Appendix I, Continued

Patients	Actual Rankings			Semantic Differential Factor E			Semantic Differential Factor P		
	Most Pref.	2nd Pref.	Least Pref.	Most Pref.	2nd Pref.	Least Pref.	Most Pref.	2nd Pref.	Least Pref.
21	B	A	C	B	A	C	B	A	C
22	C	B	A	C	B	A	B	C	A
23	B	A	C	A	B	C	B	A	C
24	C	A	B	C	A	B	C	A	B
25	C	B	A	C	B	A	B	C	A
26	C	A	B	C	A	B	C	A	B
27	B	A	C	B	A	C	B	A	C
28	C	B	A	B	C	A	C	B	A
29	B	C	A	A	C	B	C	B	A
30	C	A	B	A	C	B	A	C	B
31	C	B	A	C	B	A	C	B	A
32	A	C	B	A	C	B	A	C	B
33	B	A	C	B	A	C	B	A	C
34	C	A	B	B	A	C	B	C	A
35	B	C	A	B	C	A	B	A	C
36	C	A	B	C	A	B	C	B	A
37	B	A	C	B	A	C	B	C	A
38	C	B	A	B	A	C	B	A	C
39	C	B	A	C	B	A	C	B	A
40	C	B	A	C	A	B	C	A	B
41	B	C	A	B	A	C	B	A	C
42	C	B	A	C	A	B	C	A	B

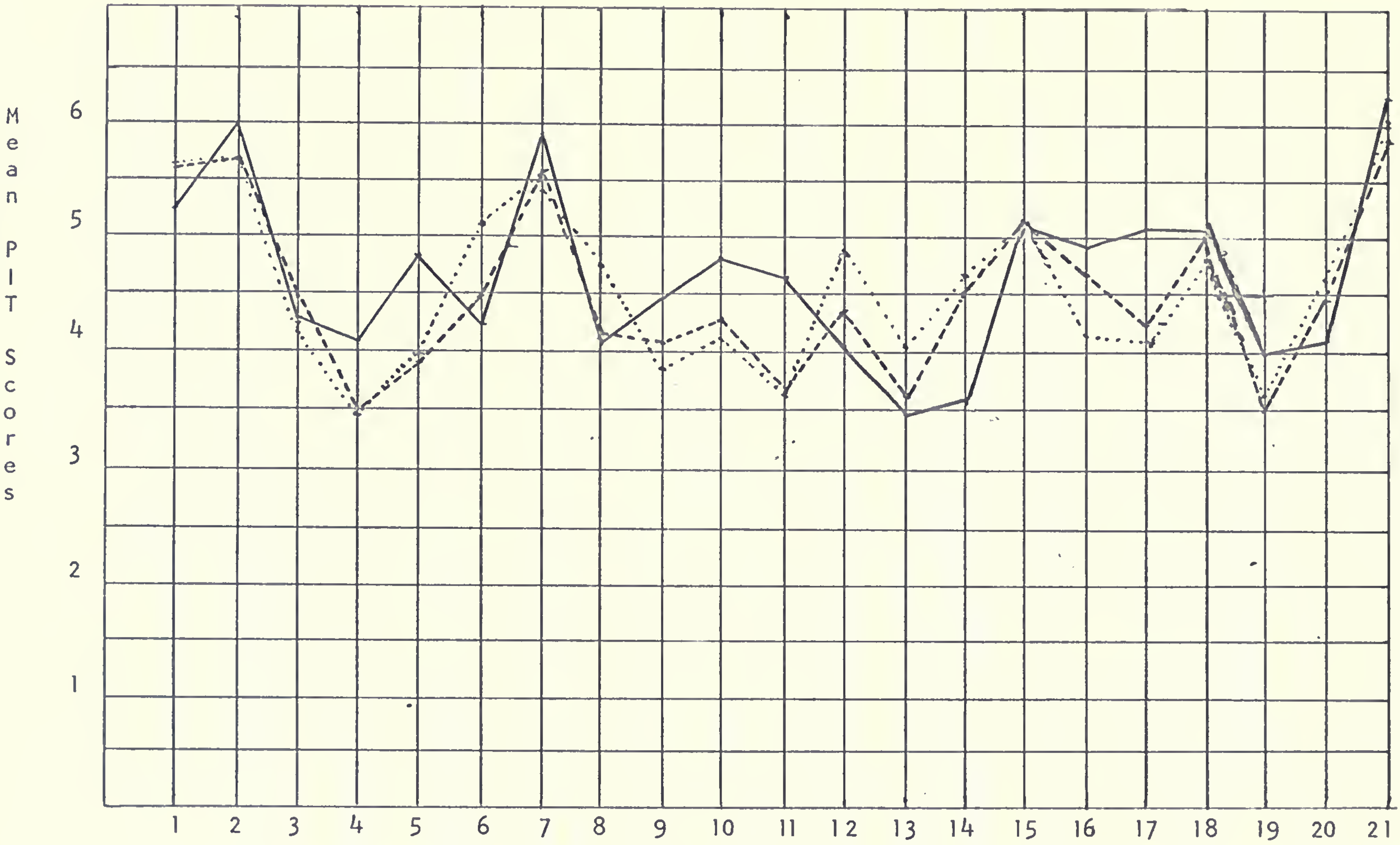


Figure 1. Mean Scores of Perceived (PIT) Needs of Therapists

REFERENCES

Apfelbaum, B. Dimensions of Transference in Psychotherapy. Berkeley, Calif.: University of California Press, 1958, 1.

Bunker, D. "Experimental Studies of Attitude Change," Unpublished term paper, Department of Social Relations, Harvard University, 1957.

Chambers, J. L. "Identification with Photographs of People," J. Consult. Psychol., 21 (1957), 232-34.

Chambers, J. L. Picture Identification Test Manual for Subjects. Americus, Ga.: Charles L. Mix Memorial Fund, Inc., 1958.

Chambers, J. L. Personal Communication. Quoted in Currier (1963).

Chambers, J. L. and Broussard, L. J.a "Need Attitudes of Normal and Paranoid Schizophrenic Males," J. Clin. Psychol., 16 (1960), 233-37.

Chambers, J. L. and Broussard, L. J.b "The Role of Need-Attitudes in Adjustment," J. Clin. Psychol., 16 (1960), 383-87.

Cohen, B. P. Unpublished study of personality and group conformity. Harvard University, 1957.

Currier, C. B. "Patient-Therapist Relationships and the Process of Psychotherapy," Unpublished Doctoral Dissertation, University of Florida, 1963.

Fiedler, F. E. "Factor Analyses of Psychoanalytic, Non-Directive, and Adlerian Therapeutic Relationships," J. Consult. Psychol., 15 (1951), 32-38.

Gollin, E. S. "Forming Impressions of Personality," J. Personality, 23 (1954), 65-76.

Gollin, E. S. "Cognitive Dispositions and the Formations of Impressions of Personality," in Festschrift for Gardner Murphy, Peatman, J. G. and Hartley, E. L. eds. New York: Harper & Bros., 1960.

Guttman, L. "The Third Component of Scalable Attitudes," Int. J. Opin. Attitude Res., 4 (1950), 285-87.

Heine, R. W. and Carson, R. C. "Similarity and Success in Therapeutic Dyads," J. Consult. Psychol., 26 (1962), 38-43.

Heine, R. W. and Trosman, O. "Initial Expectations of the Doctor-Patient Interaction as a Factor in Continuance in Psychotherapy," Psychiatry, 23 (1960), 275-78.

Heller, K. and Goldstein, A. P. "Client Dependency and Therapist Expectancy as Relationship Maintaining Variables in Psychotherapy," J. Consult. Psychol., 25 (1961), 371-75.

Hiler, E. W. "An Analysis of Patient-Therapist Compatibility," J. Consult. Psychol., 22 (1958), 341-47.

Leary, T. Interpersonal Diagnosis of Personality. New York: The Ronald Press Company, 1957.

McElheny, V. "Interpersonal Orientations and Political Opinion," Unpublished Honors Thesis, Department of Social Relations, Harvard University, 1957.

McV. Hunt, J. "An Integrated Approach to Research on Therapeutic Counseling with Samples of Results," J. Counsel. Psychol., 6 (1959), 46-54.

Osgood, C. E., Suci, G. J. and Tannenbaum, P. H. The Measurement of Meaning. Urbana, Ill.: University of Illinois Press, 1957.

Parloff, M. B. "Factors Affecting the Quality of Therapeutic Relationships," J. abnorm. soc. Psychol., 52 (1956), 5-10.

Rosenthal, D. "Changes in Some Values Following Psychotherapy," J. Consult. Psychol., 19 (1955), 431-36.

Schutz, W. C. FIRO-B. A Three-Dimensional Theory of Interpersonal Behavior. New York: Hinehart & Company, Inc., 1958.

Snyder, W. U. The Psychotherapeutic Relationship. New York: Macmillan Co., 1961.

Strupp, H. H. "Patient-Doctor Relationships: Psychotherapists in the Therapeutic Process," in Experimental Foundations of Clinical Psychology. Bachrach, A. J. ed. New York: Basic Books, Inc., 1962.

Szasz, T. S., Knoff, W. F. and Hollender, M. H. "The Doctor-Patient Relationships and Its Historical Context," Amer. J. Psychiat., 115 (1958), 522-28.

Vogel, J. L. "Authoritarianism in the Therapeutic Relationship," Unpublished Doctoral Dissertation, University of Chicago, 1959.

BIOGRAPHICAL SKETCH

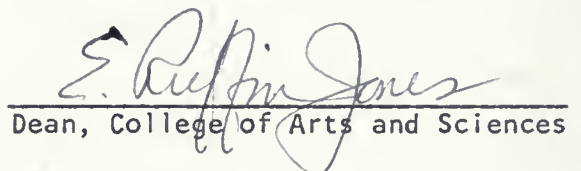
Noel Arthur Plummer was born on December 28, 1936, in Johnstown, Pennsylvania. He graduated from Portage Area Schools in May, 1954. He received a Bachelor of Science degree in Psychology from Juniata College, Huntington, Pennsylvania, in June, 1958. In June, 1960, he received a Master of Science degree in Psychology from the University of Miami in Coral Gables, Florida. He entered the doctoral program at the University of Florida in September, 1960.

While at the University of Miami he was elected president of the University of Miami Chapter of Psi Chi, a national honorary society in Psychology. Since coming to the University of Florida, he has held clinical assistantships at the Reading Clinic, the University Counseling Center, and the Department of Psychology. He interned at the J. Hillis Miller Health Center from September, 1962, to August, 1963, with support from the Office of Vocational Rehabilitation. In September, 1963, he was awarded a National Institute of Mental Health Fellowship while completing his dissertation. He also held a position of instructor in the Psychology Department while teaching a graduate course in psychological testing. For the past two years Mr. Plummer has been employed as a clinical psychologist with the Indiana County Guidance Center, and as Associate Professor of Education and Psychology at Indiana University of Pennsylvania, Indiana, Pennsylvania.

Mr. Plummer is married to the former Nancy Evans of Portage, Pennsylvania, and is the father of two children, Evans L., age 7, and Joel Justin, age 3.

This dissertation was prepared under the direction of the chairman of the candidate's supervisory committee and has been approved by all members of that committee. It was submitted to the Dean of the College of Arts and Sciences and to the Graduate Council, and was approved as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

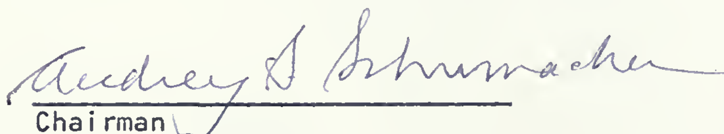
April, 1966



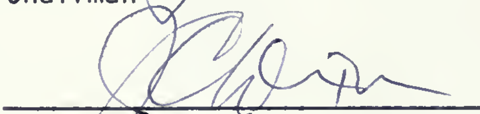
Dean, College of Arts and Sciences

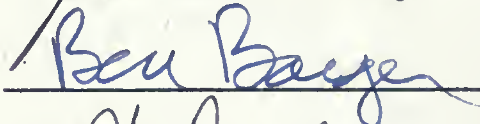
Dean, Graduate School

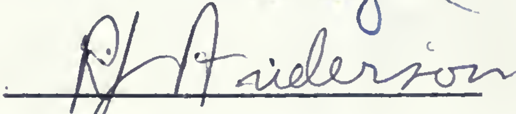
Supervisory Committee:



Chairman







4660 4